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The Illinois State Medical Society



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severe asthma

is usually aggravated

and prolonged

by a strong emotional overlay

In one study, 'Thorazine' relaxed and improved 11 of 12 patients within one hour after injection . . . in one case "appeared to be life-saving."[1]

'Thorazine' promptly alleviates the emotional stress which may precipitate, aggravate or prolong an asthmatic attack. It enables the patient to sleep, yet does not depress respiration.

Available: Ampuls, Tablets, Syrup (as the hydrochloride), and Suppositories (as the base).

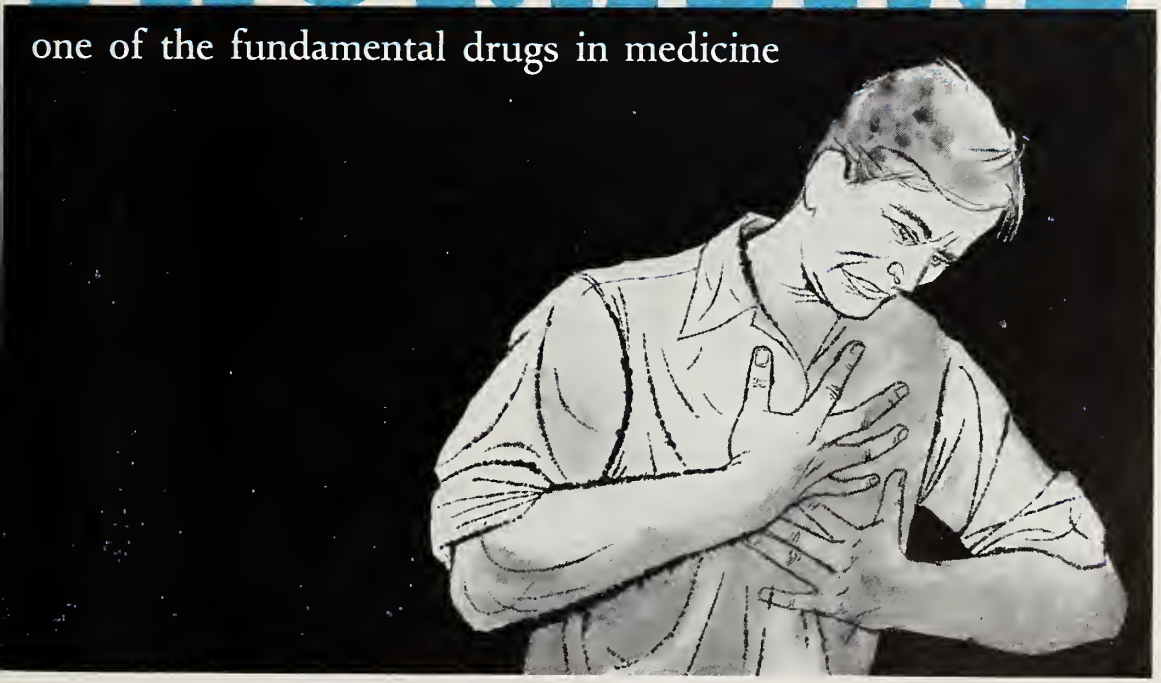
Smith, Kline & French Laboratories, Philadelphia

1. Ende, M.: Am. Pract. & Dig. Treat. 6:710 (May) 1955.

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

THORAZINE*

one of the fundamental drugs in medicine



The Month in Washington

Washington, D. C. — A new venture in federal medical care—the armed forces dependents medical care program—was launched on schedule December 7, and 2 million dependents of servicemen became eligible for hospitalization and extensive medical care.

The "medicare" program, because it is a pioneer effort, will be watched closely by members of Congress, the armed services and the medical profession. Congress will be interested in keeping track of the cost of the program as well as the availability of care.

The Defense Department has earmarked $41 million for the program through next July 1. Thereafter it is estimated the cost will run between $60 million and $70 million a year. When the program is operating at its peak, as many as 800,000 dependents not now getting care at U. S. expense are expected to be participating.

In all but a few states, provision of medical care outside military facilities is being made under agreements signed between the state medical societies, contracting agent (generally Blue Shield) and the Army which is the executive agent for Defense

The contracts run for seven months, and all states are expected to renegotiate contracts prior to their expiration next July 1. New contracts naturally would reflect the experience gained since December 7.

As the vast new project went into force, the newly created Office of Dependents Medical Care (ODMC) stressed that the law intended that civilian medical care under the program should be comparable to that provided in armed services facilities. Participating physicians receive payment in full from the goverment under a published schedule of allowances. ODMC said this means that the doctor will receive payment for his usual charge or the amount set in the schedule, whichever is less.

ODMC made these additional points:

1. In instances in which the physician believes that an allowance greater than that prescribed in the local schedule is justified, he should look to the government rather than the patient for payment. Provisions have been made for him to submit a special report to his state medical society and the society, in turn, to the government.

2. Military dependents may submit as identification their post exchange card, the combined post exchange-commissary-military medical care card, or the standard military dependent identification card. A special medicare card is being prepared, and after next July 1 will be the only identification allowed for this purpose.

3. There are no plans in Defense for authorizing payments for drugs, medicinals or other medical supplies, except those furnished while hospitalized or those administered directly by a physician.

4. The claim form to be used by physicians in the medicare program is called "Statement of Services Provided by Civilian Medical Sources." ODMC said sufficient supplies have been furnished by all state agents.

5. The law and implementing regulations do not permit payment for any medical care, services or hospitalization prior to December 7; this includes prenatal care.

The broad outline of legislative proposals to come from the administration in the newly con-

(Continued on page 32)

In the arthritides . . . a prudent course



Ulysses and the Sirens—from a vase in the British Museum

between the hazards of high steroid dosage and the frustration of inadequate relief

Because of the complementary action of cortisone and the salicylates, Salcort produces a greater therapeutic response with lower dosage.

One study concludes: "Salicylate potentiates the greatly reduced amount of cortisone present so that its full effect is brought out without evoking undesirable side reactions."[1]

SALCORT®*

indications:

Rheumatoid arthritis . . . Rheumatoid spondylitis . . . Rheumatic fever . . . Neuromuscular affections.

[1]Busse, E.A.: Treatment of Rheumatoid Arthritis by a Combination of Cortisone and Salicylates. Clinical Med. *11*:1105.

each tablet contains:

Cortisone acetate	2.5 mg.
Sodium salicylate	0.3 Gm.
Aluminum hydroxide gel, dried	0.12 Gm.
Calcium ascorbate (equivalent to 50 mg. ascorbic acid)	60.0 mg.
Calcium carbonate	60.0 mg.

**U.S. Pat. 2,691,662*

The S. E. MASSENGILL Company, Bristol, Tennessee

NEW YORK • KANSAS CITY • SAN FRANCISCO

WASHINGTON (Continued)

vened 85th Congress was first sketched by HEW Secretary Folsom in several appearances before newsmen in December. Among them are: (1) federal grants to medical schools for teaching facilities, (2) authorization for smaller insurance companies to pool resources without violating the anti-trust laws in an effort to encourage expansion of voluntary health insurance. (3) increased attention to problems of older persons, particularly in health and adult education, (4) continued expansion aand improvement in vocational rehabilitation, and (5) expansion of staff and facilities of the Food and Drug Administration.

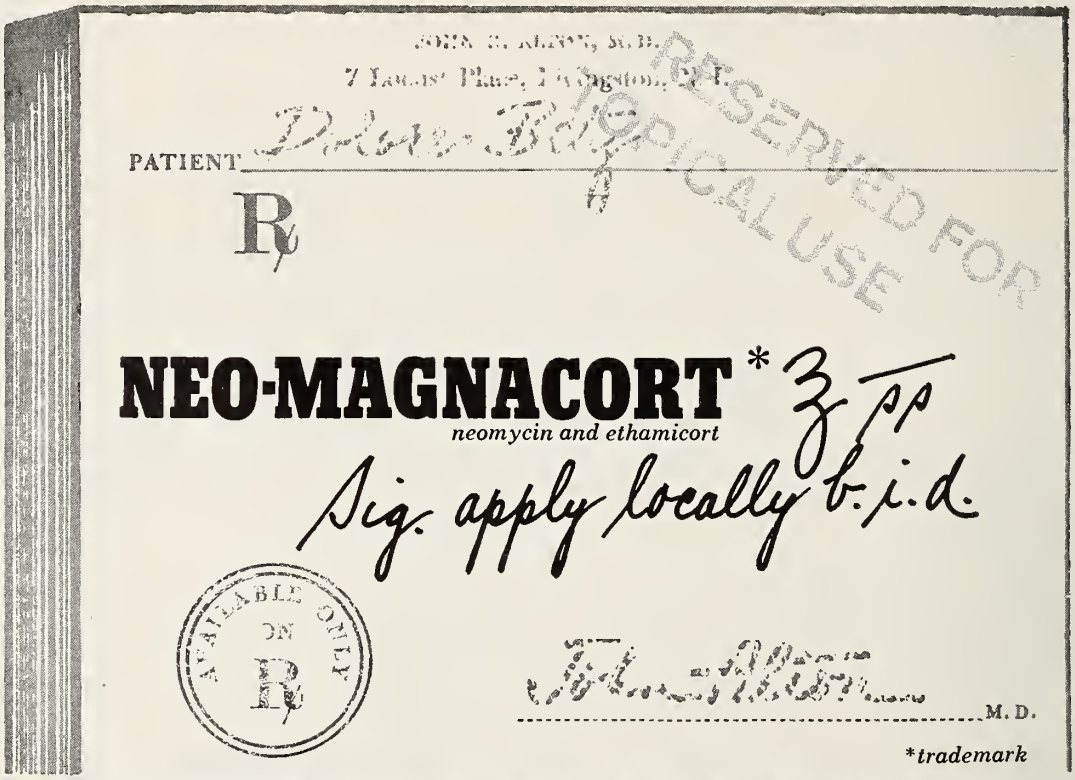
Following up President Eisenhower's plea for increased utilization of backed up stocks of Salk poliomyelitis vaccine, Secretary Folsom told a National Press Club audience: ". . . we have a new danger — the danger of public apathy. It is ironic that in the face of such a dread disease, larger quantities of the vaccine are not being used." The President has urged that the vaccine be given additional groups, including young adults.

NOTES

A "package" bill combining both basic and major medical expense insurance is being worked on by the Government for its civilian employees . . . A special advisory committee headed by Dr. Russell Nelson of Johns Hopkins Hospital has asked hospitals to set up pilot projects to see how to revise care given long-term patients in hospitals, and also cut costs . . . The national illness and disability survey voted by the last Congress will be supervised by Forrest E. Linder, PhD., former head of social statistics for the United States. . .

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There is much evidence that the immunity resulting from primary infection in childhood is bought at a great price. The risks that it entails are not small, since tuberculosis infections that remain latent during the early years of life may flare up in the form of overt disease after puberty. René Dubos, Am. Rev. Tuberc., Aug. 1956.



PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc., Brooklyn 6, New York

The
ILLINOIS
Medical Journal
Official Journal of The Illinois State Medical Society

JANUARY, 1957
VOL. 111, NO. 1

A New Approach to the Emergency Treatment of Sickness Caused by Narcotic Withdrawal

EUGENE F. CAREY, M.D., CHICAGO

AS a surgeon of the Chicago Police Department, I am frequently called upon to treat a sickness, (rare to most doctors, but common to the police), which overcomes narcotic addicts, who have been deprived of their drugs by enforcement officers.

The condition is called "narcotic withdrawal sickness", and is characterized by definite signs and symptoms. Its severity depends upon the strength of the drug the addict is using at the time of withdrawal, as well as the location where the withdrawal occurs. Apart from these causes, neither sex, race, color nor age seems to have much or any effect. The strength of the drug (generally morphine or heroin) will depend entirely upon the amount of and frequency of dilution of the "market" supply and the number of dope peddlers through whose hands the narcotic has passed before its purchase by the addict.

There are several ways in which withdrawal sickness may be brought on and which can govern its acuteness.

First: By a simple home reduction plan. Here, surrounded by his family or friends, the patient decides to reduce his dosage, or to go on a diet. His supply and his source of supply are good. He can govern his sickness according to his will. His mind has nothing on it but a desire to cut down his load a little. So he takes the "bite" as much as he wants.

Second: "The Market Panic." This follows unlooked for pressure or a raid by enforcement officers. The source of supply is suddenly knocked out and the peddlers are jailed or scattered. Here the addict or "junkie" is faced with a great problem. Suddenly he is forced to go on "short rations." His holding supply of the drug usually is very small, and he begins to worry. Sooner or later his worry becomes a "panic." He knows that if he runs out he can't borrow a shot from any of his friends even if they know it will save his life. Nor will he part with any of his own supply at any time, for a genuine morphine addict is notoriously one of the world's most miserly persons. No matter how great his supply may be, he will never part with a bit of it. He will suggest you go and find yourself a peddler as he did. Hence, when an addict tells you that he got his first shot from another addict, he is lying. The truth is that he got his first shot from either a pusher or a peddler.

Presented as part of the New York Academy of Science's Conference on Reserpine, February 3 and 4, 1955.

Surgeon, Chicago Police Dept.

Third: The cure: Often an addict will decide to take the "cure." Mostly this act is born of his own free will, and there are two ways he can go about it. For example: either he or his family may have the means to buy his way as a patient into a sanitarium, or, he may volunteer as a patient in a governmental treatment facility. Wherever he lands upon the cure route, he knows he will receive adequate care and be given either a gradual reduction treatment or else a substitute drug. In a sense, this all amounts to a sort of vacation. Wherever he is able to go, he no longer has a care in the world. His troubles are all left on the outside. He knows he came of his own volition, and that he may leave at his own request and convenience. It is surprising how many of these people take the cure, because they want to hide out for some reason, and at the time talk about possibilities in other towns with those who are likewise taking the cure. Narcotic enforcement officers are prone to argue just how far away from a cure institution many of these addicts get before they again take a shot.

Fourth: "Kicking the habit": This happens when an addict is picked up by the police and lodged in jail. He is detained in a concrete floored, steel barred cage or cell after he has been catalogued and screened. Then he is left to his own resources. There may be other addicts in the same cell with him. None knows what is next on the agenda, what is to happen to him, or where he will go. In time, the drug within each one's system begins to wear off. One yawns, then they all yawn. Next follows lacrimation, retching, vomiting, running bowel, twitching, jerking. Their vertebral canal seems to fill with ice water, they say, and soon this chilly ache becomes a tortuous, unbearable freezing pain, not alone in the back, but all over the body. It causes them to cry piteously, scream and convulse. This is withdrawal sickness.

In each of the four ways mentioned, it is easy to see that the mental attitude of the patient plays a very important part in his sickness. It gives some insight as to how the patient may feel about the onset as well as the outcome of his sickness. This attitude can and does have much to do with the whole affair. We must remember then that his mental attitude is of paramount importance to the addict, and can, in fact make or break him.

We do not pretend to know why addicts take drugs. All we have ever found out is what they tell us, that the taking "makes them feel normal." This, of course, means that taking a drug brings about a feeling that is pleasing to the addict. It is his idea of how he wants to feel. It must follow then that a non-addict's feeling of normalcy would be abnormal to an addict. The addict takes his drug and when that peculiar feeling of his norm begins to permeate his entire system, then, and only then, does he feel normal, and the larger the dose, the greater becomes his feeling of normality.

You will note that we mentioned morphine and heroin earlier. This was done in order to direct your attention to the fact that there are two types of addicts. Although both drugs come from the same source, each creates its own individual kind of addict.

Morphine produces a passive type of individual, a group comprising slinking, cringing persons such as the petty thief, the shoplifter, the pickpocket, or the prostitute. When they steal or purloin the property of someone else they take only enough to enable then to buy a supply of their favorite drug.

Heroin, on the other hand, develops the vicious killer who so often resorts to cruel, inhuman, lustfully barbaric sorts of crime. He may and can easily become one of the assassin type, who frequently teams up with a heavy marihuana smoker. For some unknown reason these addicts seem to flock together; just the opposite to the morphine takers. They try to look alike; the zoot suiters of yesterday, or the ones of today that we recognize by their tight fitting dungarees, cowboy boots, hatless and with "D.A." haireuts and sideburns, and open zippered sport jackets.

The "ladies of the needle" too, have a peculiar mental quirk. Their twist is not the oldest but certainly is one of the oddest to come down thru the years. Long ago the professional prostitute noted cessation of menses when she became an addict. This, she reasoned would accomplish two things for her: It would act as a contraceptive by stopping the menstrual flow, and it would permit a longer working month. The second idea worked out well, but the first idea did not al-

ways hold true. Consequently many a child was born who "kicked a habit" during the first few hours of its life.

Going back for a moment, you will again note the mention of two drugs, this time heroin and marihuana. While their potentials for activating the mental attitude are somewhat similar, their origins are far apart, as are their ways of taking hold upon a person. For example: heroin invites "addiction" as does morphine or any other of the opium series. On the other hand, marihuana invites "usage," as does cocaine. The reaction of the opium drugs when withdrawn, invites a definite and severe withdrawal sickness whereas, with cocaine and marihuana, the end results are but a transient although highly nervous condition.

An addict's definition of addiction is "It is a condition brought about by something I take that I cannot get along without, because I get deathly sick without it." Here we see the allusion is to a siege of sickness following withdrawal of narcotic drugs. Thus, many of us feel that the withdrawal of anything which does not invite withdrawal sickness suggests the word "usage" rather than "addiction." It might be well to mention here that those who take cocaine or marihuana, could be designated as "users" just as are those who take alcohol, tobacco, coffee, etc.

Formerly we were able to find cocaine users more easily than we can today. Perhaps this drug has lost its popularity because marihuana is cheaper and easier to get. Cocaine, like heroin, may be sniffed up the nose or used hypodermically. Regardless of how used, whether sniffed or "main lined" directly into the vein, as heroin usually is taken, it is known as a pleasure "pop." The euphoria and super-stimulation following a "pop" of cocaine is most welcome to the tired thinker, especially if he is of the type who oft time tends to sympathize with himself as do some business men, scholars, musicians, and other professional people. Sometimes the dose is taken so frequently or is so large, a feeling of generalized anesthesia, freezing, or extreme excitability follows. Thus is invited an antidote such as morphine, which when repeatedly taken as an antidote, will bring about addiction.

Once in a great while we find a fellow who is a "flier." In other words, he uses what is known as a "speed ball," which is a mixture or combination of both heroin and cocaine. He will tell you that the reason he uses a combination such as this is because he gets his "jolt" or effect quicker and that it sends him "higher." This type of addict-user can become the most troublesome of all known drug takers, because he can and often does, lose every vestige of sanity. As a rule, this "speed ball" is feared by nearly all who use dope, and the only reason one may possibly have for using it is to have something to brag about when a meeting takes place with others of the so-called "cloud riders."

Fear is the most important concern in the life of an addict. He fears he may run out of the stuff. He fears there may be a supply panic. He fears anything and everything that may have a bearing on his drug. Will he get it? Will he not get it? Will it be too adulterated? Will it be too strong? Yes, he even fears that his stuff, particularly heroin, *may* be too strong. There is a very good reason for this fear. Because of a supply panic, or anything else that may affect the market supply, the pusher or the peddler begins to add more and more adulterant. As the drug becomes weaker and weaker because of this adulteration the addict in fact, begins unknowingly to undergo a reduction cure. Thus you can see that in time the stuff he may be taking *could* consist of nothing more than the adulterant, usually milk sugar. This being so, it readily follows that if the police pick up the addict at this time, he may have very little drug in his system. Thus it follows that his withdrawal sickness will be a very light attack. Hence the interrogater's work should be lessened, and so should that of the doctor. However, the fear of a potential sickness now overwhelms the addict and this results in our having to do with an exceptionally noisy patient who is totally overcome with a self-pity anxiety. Now he may develop a needle habit and enjoy making a human pin cushion of himself.

On the other hand, the fear of too strong a dose is a *real* fear, as the addict using heroin knows that too strong a dose may kill him. A strong killing dose of heroin is known as a "hot shot" and is usually given by the peddler to a "too talkative to the police" addict in order to shut him up. "Dead men tell no tales" nor does the recipient of a "hot shot" and it does

not leave a clew in a body previously saturated with heroin.

All these details are known to be basic psychogenic factors which govern those who take drugs. While we have accumulated much information about those who take drugs, their habits, places of abode, where and when to find them, as well as a world of knowledge pertaining to their drugs nobody, not even the taker of the drug himself (be he a savant or a moron), can give you any better reason for taking it than that already mentioned: it makes him feel "normal."

As was said earlier, there are in general, four ways of bringing on a withdrawal sickness; in the home, because of a panic, as a patient in a sanitorium, or by being jailed.

We of the police department have to do only with those narcotics prisoners who receive our treatment during the few hours they are in our jail. The treatment we give is predetermined by the Federal Narcotic's Law, which is known as the Harrison Act. For one dollar a year, we doctors can register with the Internal Revenue Department and in turn get a special tax stamp which permits us the use of opium, coca leaves, marihuana, etc., in our practice of medicine; and to do this to the best of our judgment. But, says this law, in a sense, "Do not let us catch you using your judgment." Now, this interpretation may sound funny, but really there is nothing funny about it. It makes you think and when you have given proper thought you understand that it really means "Have nothing to do with a known addict or user of these taboo drugs anywhere at any time, unless it be in a regularly recognized institution designed and equipped to care for such patients." By following this advice you will have nothing to worry about in your practice, regardless of your specialty.

At our Central Police Headquarters in Chicago, we have a department set aside for narcotic offense cases. It is supervised by Lieut. Joe Healy who directs the police narcotic activities all over the city, as well as his aides within headquarters. Two of these headquarters' aides are those old time narcotic police officers, William Freund and Harry McMahon. They interrogate and catalogue all narcotic prisoners picked up by the police and this author has been associated with them. In their years of helping interrogate, catalogue and detain over 30,000 narcotic offenders, both Freund and McMahon have developed clever approaches to the several types of prisoners, and this, in turn, enables them better to understand and read reactions, as well as to obtain needed information.

It might be well to point out here the law does not require that a person shall be jailed simply because he takes a drug. Some reasons for being jailed are because he may be picked up for possession, peddling of drugs, for robbery or for some other crime. All of this comes out during interrogation and cataloging while he or she is in detention for the few hours before being sent before the narcotic's court judge, who disposes of the case either by dismissal or ordering a short jail term or a long penitentiary sentence, as the case may warrant. Remember please, that the prisoner's detention in our police headquarters rarely exceeds 48 hours and generally 24 hours or less.

Now those of us who attend a prisoner affected by withdrawal sickness know about the Federal Act, which governs the use of drugs listed in the Act. We also know that the ideal treatment for this sickness would be a dose of the drug used by the addict. We also appreciate that we are not equipped as a narcotic hospital or as any kind of institution or clinic designed for the work of treating addicts. We also know that Uncle Sam frowns upon treating narcotic cases in a cell room for but a few hours, because this is a long drawn out affair wherein the addict should receive recognized and adequate care. Above all, we remember that we are doctors within the police department and that we, too, are a part of it. But even so, we must abide by the law just as does any other doctor who wants to stay out of trouble with the government. This being so, how then do we treat our narcotic addicts?

Well, to begin with, conditions would be better all the way around if we were permitted to utilize any of the high grade substitute drugs (Demerol,® Dolophin®) available today. But the sad part of all of this is that these drugs which are recognized as real substitutes, and

so used in proper treatment institutions, also have their usage governed by the Harrison Act. Thus, they too, are out of our reach. Nor can we send the patient to a local hospital, for no hospital will accept a narcotic case, especially one sent in under police escort.

About the most useful emergency drug applicable to our narcotic cases is a heavy dose of bromide. In order to do any good, however, the dose must be very large and frequent. Here we have a drug which because of a necessarily large dose will most times upset a stomach undergoing narcotic withdrawal. Then again we invite not only a servere bromide rash but a new kind of habit, bromism.

Another medication used is barbiturate. Here too, is needed a large dosage, one that provokes a poisoning problem of its own as well as a habit. Adding an additional stomach upset by either the bromide or the barbiturate to that of the withdrawal sickness, does not seem to do the patient any good. It doesn't make sense.

Recognizing the fact that a metropolitan police headquarters lockup is not a place in which to treat a narcotic patient because there are no beds; no regularly organized nursing care; that the prisoner is with us for only a few hours at the most; and finally, that there is no opportunity for the police doctors to follow up a case, it becomes apparent that we who have to do with a passing or temporary narcotic treatment problem are ever on the lookout for and ready to welcome any pharmaceutical product we can lawfully use, and above all one that will cancel out the mental terrors and fears which overcome the addict when he is "freshly plucked from the tree" and brought to police headquarters, where he is faced with an attack of narcotic withdrawal sickness.

In the medical journals some time ago, we began to find news concerning Rauwolfia serpentina and how it was being used in hypertensive cases. After a time, we began to use serpentina on a few addicts who were hypertensives. Unfortunately, these prisoners had left the lockup before we got around to see them again. But on asking another prisoner or two as well as our interrogation men, we were told they were all right when they left. Of course, we never fully knew from this what "all right" meant.

As time went on and the pure alkaloid Reserpine® was presented, we began to hear of its use in mental cases and the remarkable results obtained thru its use. Somehow or other, we failed to compare the narcotic addict's mental problem with that of any other mental case. However, one day we saw some pictures of a vicious monkey and read how this new drug calmed down the animal and brought him around from an anti-social to a social attitude. This little item "clicked" and the descriptive word "tranquilize" stuck. It caused us to wonder how it would affect a narcotic addict. When we first began to use this new drug, our thoughts were that if it would do a little tranquilizing here, maybe we would have something worth while. So, we tried it. We did not meet with much success. The tablet size we used was 0.25 mg. and we were guided by the dosage suggestion on the label. So, we increased the dose to four tablets or a total of 1 mg. Returning to the cell block in about two hours, we thought we detected a more eased attitude on the part of our patients.

The next day, our given dose was 2 mg. per patient, and on our returning in about two hours, we found that these patients who had been yawning and beginning to jerk and retch a bit, were now comfortable. Some were dozing and some were even sleeping.

After about two or three more days, both Freund and McMahon asked what kind of new medicine was being given to the addicts; whatever it was, they were certain it was making their work of interrogation and cataloguing much easier because the prisoners were calmer, less jumpy, and more responsive.

After explanation we enlisted the help of these officers and with their help we managed to keep records concerning more than 300 temporarily detained drug-taking prisoners. Thus, in this way we discovered the following facts:

(1) Any drug addict or user who comes into being as such because he sought a thrill or because of curiosity can be tranquilized and sedated by the use of Serpasil,® and it is quite possible that a follow-up of these people would reveal a complete warding off of the dreaded narcotic withdrawal sickness under this treatment.

(2) Furthermore, it seems quite possible that those who use narcotic drugs because of some painful ailment, can be tranquilized and sedated by Serpasil to such an extent as perhaps to be able to give up habit-forming drugs and to get their pain relief from a much less vicious source.

(3) Also many of these drug addicts appear psychologically to intensify their pain by the use of habit-forming drugs and there is every reason to believe that Serpasil can and will help to diminish this sort of psychic pain.

(4) As to the time element pertaining to the response to Serpasil we found: The morphine addicts respond in about one and one-half hours after oral administration; the heroin addict in about two hours after oral administration, and the alcoholic and marihuana user usually in less than one hour. The parenteral form of Serpasil was not used at any time. The age brackets were 18 to 30 for heroin addicts, most of whom were the nervous, jump, noisy type, and who were mainly colored females. The age range of the morphine group was from 30 years upwards, with white females predominating.

As we went along with our investigation of Serpasil, we began to wonder if we were being carried away by undue enthusiasm. Thus when we discovered Ciba Pharmaceutical Products would supply us with an identical looking and tasting undetectable placebo we were more than happy to carry on the work we had started. When these were received, we decided to deputize both of our narcotic police officers as our "interns" and as such we left with them an adequate supply of Serpasil placebos with the suggestion that they give these tablets to their charges whenever they deemed it necessary.

This they agreed to do, but for some reason or other they never could understand why it was that the tablets they gave out did not tranquilize and sedate in the same manner as did those dispensed by the doctor. Someday we may let them in on the secret, but meanwhile they believe that the doctor has a certain knack for handling medicine that is quite different from the way a policeman handles it.

In conclusion, we again call your attention to the facts that:

1 — This experiment was carried out in a police station;

2 — The experiment was tried on freshly arrested prisoners;

3 — The daily time period of the experiment was limited to a few hours because the transfer of prisoners to other locations left us no opportunity for follow up;

4 — Our dosage began with two 1 mg. tablets and was repeated in four hours, if needed;

5 — The dosage asserted itself within one and one-half to two hours after oral medication;

6 — The morphine addict responded to Serpasil more rapidly than did the heroin addict;

7 — Marihuana users were readily influenced by Serpasil, as were the alcoholics, while the dose for both was smaller;

8 — Last but not least, we believe there are certain possibilities offered by Serpasil that warrants further investigation by other police departments as well as by other organizations having to do with the narcotic problem, if only because the tranquilizing sedation brought about by this new drug apparently wards off the withdrawal sickness so feared by all addicts.

We all know that the manufacture, use or possession of heroin is not permitted within the continental United States or its possessions, and this same regulation has been adopted by many other countries. We know that heroin has absolutely no place in medicine and so is not used by the healing profession. Furthermore, we know that the great source of contraband heroin supply is RED CHINA. We also know that an addict fears the mental torture of going without his drug more than anything else on earth. He also hates and fears those mental problems that face him on the long road to recovery. This he will tell you is really the thing that encourages him to go back to the stuff over and over again.

Now, we also all know that an addict is the world's greatest liar. As a matter of fact, it is the only bit of defense mechanism to which he can and does lay claim. However, he does have his moments when "everything is rosy" and it is during these periods that he will confide his fear pertaining to his mental well being during and after withdrawal.

Should further study bring to light the fact that organized follow-up treatment confirms our experimental Serpasil findings wherein we apparently erased the fearful mental aspects of narcotic withdrawal sickness from the picture, then we feel this growing national plague, this known vicious contraband, narcotic laden communistic invasion into the ranks of our American youth can be combated more readily. Surely this in itself should encourage further investigation.

My final word is to express my indebtedness to Commissioner Timothy J. O'Connor, Commander of the Chicago Police Department, and to his chief surgeon, Doctor P. S. Vitullo. Also, I acknowledge the help of my friend, Doctor William Braid White, who gave me valuable assistance in manuscript arrangement.
1121 S. State St.

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Roentgen Evaluation of the Chest

C. H. Warfield, M.D., F.A.C.R., Ft. Wayne, Indiana

THIS paper is not written to offer any special methods of diagnosing pathological processes but as an appeal to be on the alert for conditions of the lung that in the past have been considered either insignificant or not amenable to treatment. It therefore should be apparent that the proper evaluation of chest films becomes very important if we are to aid the referring physician or give the patient our best opinion. We, as physicians, are charged with the responsibility of offering not only as correct a diagnosis as possible but of treating the patient with the latest and the best. The type of treatment may not be available in your community but it is available. It is our responsibility to refer the patient to a physician who can offer the best form of treatment. Some physicians will contend that the described condition is not amenable to treatment only because they are not aware of newer methods of treatment.

Proper evaluation has been brought about by better and more acurate methods of determining the exact diagnosis. Radiologists are more and more concerned with certain pathological conditions of the lungs that require immediate attention or conditions that require further study to determine if the pathology will disappear under ordinary treatment or more drastic treatment is indicated.

Surgery of the chest is now as easy and safe to perform as exploration of the abdomen has been for many years. It is no excuse not to explore lungs for diagnostic purposes so that you and the patient definitely know whether the pathology is benign or malignant.

Several years ago the early diagnosis of tuberculosis was paramount in our discussions, yet it is fair to say that the subject has changed to primary bronchogenic carcinoma. Methods of examination, mass surveys, etiology, early treatment and patient interest in the disease keeps us on the alert. Many have asked the question whether mass surveys will detect early bronchogenic carcinoma. Garland[1] reports that the average yield of bronchogenic carcinoma in mass surveys is about 10/100,000 adults which is quite low. He also states that probably no more than half of the suspects ever seek confirmation of the diagnosis or treatment. Also it is obvious that when a suspicious lesion is found in a miniature film it would be costly and time consuming to

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the patient only to find out the suspicious lesion was of no significance. In a study of bronchogenic carcinoma by Sokoloff[2] 11 out of 22 cases were not seen on the microfilm even in retrospect. It has been accepted generally that the diagnosis of any pathological condition by micro-film may be overlooked by two per cent even when dual reading of films is undertaken.

During the last ten years more and more hospitals have installed photo-roentgen units to obtain pre-admission chest films. This was initiated to prevent active open cases of tuberculosis from infecting personnel as well as otherwise well patients. It was not intended to be used as another diagnostic tool but a method of screening. In my opinion no diagnosis should be offered on these miniature films but if pathology is suspected then conventional films and study should be done. Referring physicians have been found to either disregard a pathological process found in a miniature film or to consider the miniature film sufficient for diagnostic purposes.

Thus it would seem that if the early recognition of bronchogenic carcinoma is to be accomplished, a careful study of technically perfect films by competent observers is the answer to the problem. I do not mean by using the plural, that two radiologists should study the films but another competent physician who is acquainted with the normal chest and its variations.

Early lesions of bronchgenic carcinoma may be located in the hilus area of the lung and be completely obscured by the normal hilus structures. They can be obscured by movement of the hilus produced by cardiac pulsation which can be prevented by exposures of 1/40 of a second or shorter. Also films taken using a higher kilovoltage and a shorter time may be of an advantage in order to actually penetrate the hilus area. Lateral films of the chest in this type of case are of little value because of superimposition of shadows. Bronchograms may be of great value when the lesion has encroached into the bronchus yet has not eroded the bronchus to produce hemoptosis.

Localized areas of emphysema adjacent to the hilus may give the clue to the early diagnosis of a bronchogenic carcinoma. In this type of case the tumor may be extra luminal but pressing against the bronchus sufficiently to let air enter that segment of the lung but not escape. Later, as the tumor enlarges, the emphysema will disappear and be replaced by a similar area of atelectasis. Thus the area of consolidation will not represent the size of the carcinoma but will be that area of the lung supplied by that bronchus.

At this point it is also well to point out that a bronchogenic carcinoma and its atelectatic area may become infected resulting in cavitation. If this occurs, depending on its location, it may very closely resemble tuberculosis with cavitation. Cases of this type have been treated as tuberculosis and likewise a bronchogenic carcinoma may develop in a proved case of pulmonary tuberculosis. Even pneumonias may caseate, producing cavities.

The types of primary carcinoma of the lung that originate in the parenchyma or the pleura are most difficult to diagnose since they may resemble normal variants or residual pathology. Such a simple condition as callus from a former rib fracture or a benign tumor of any part of the thoracic cage may at first cause alarm. A small area of thickening of the pleura may well be a primary carcinoma. A case of this type recently came to our attention where the patient complained of localized pain in the chest wall. Only after studying the chest at several angles was the area of pleural thickening demonstrated.

Residual pneumonia regardless of etiology still remains very troublesome. We have seen cases of residual pneumonia and certain specific types of pneumonia subjected to lobectomy and pneumonectomy where more care and study should have been done before a hasty surgical procedure was performed. Also we have observed cases where the patient refused surgery only to find a short time later the pathology had completely disappeared without therapy of any type. Inflammatory lesions of the lungs are still some of the most difficult to differentiate from primary malignancy. They require close scrutiny and careful study by the radiologist and referring physician since even a few weeks lost in waiting may be the difference between a cure of a malignancy or a bad prognosis.

Such lesions as the isolated round foci or coin lesions have been of much concern in recent years. For many years these isolated, well circumscribed lesions of uniform density were considered as tuberculomas.

Good[3] reported that 42% of non-calcified solitary rounded lesions proved to be malignant. This report should be of concern to every physician who knows a patient who has such a lesion. It also should be made clear that the size, location, density and contour are of little value in determining whether the lesion is benign or malignant. Even central calcification is no sign that the lesion is benign. If this type of lesion has not changed in several years then it may be considered benign but if first seen in a patient 35 years or older surgery is imperative.

Single hematogenous metastasis has the same appearance as these solitary lesions. Such lesions could be removed only to find the patient has a hidden primary carcinoma elsewhere. However it is not considered bad practice to remove a solitary lung metastasis where the primary malignancy has previously been removed.

Emphysema is a disease of the lung frequently overlooked or completely disregarded. Sometimes overaeration is present resulting in a much darker film than usual so that the supposed overexposure is blamed on the technician without trying to blame it on emphysema. Since emphysema is one of the causes of dyspnea and eventually cardiac insufficiency, we should pay more attention to its presence. The emphysema can be recognized as a localized process which may be the sequelae of a pre-existing disease process where the lung tissue expands into an area vacated by the disease process.

Bullous emphysema usually located in the base of both or one lung is fairly easy to recognize as annular or multangular shadows and should not be disregarded as a lack of lung markings or merely overexposure.

In many cases emphysema is diagnosed clinically as asthma with the condition persisting for years until surgical correction is almost impossible. Recently we studied a patient with large bullæ occupying the upper half of the left lung with smaller blebs in the lower half of the left lung. The result was a marked shift of the mediastinum to the right causing marked dyspnea. This process had proceeded to the point where the patient was having frequent pulmonary infections so the referring doctor and patient wanted something done. The elapsed time of this supposed asthma case makes it almost impossible to offer this patient any relief.

Marginal emphysematous blebs are rarely seen on films yet they are the most frequent cause of spontaneous pneumothorax. These ruptured blebs are the reason a pneumothorax persists for days and even weeks.

Solitary lung cysts may be connected to the bronchial tree thus easily becoming infected producing an abscess. Large cysts may compress adjacent lung tissue producing atelectasis which also may predispose to infection. Cysts connected to a bronchus may develop a valve action so they fill with air but do not thus rupture as may happen in hydrothorax, penumothorax or pyothorax. Cysts may continue to enlarge, displacing the mediastinal structures so that they may resemble a tension pneumothorax.

Pneumothorax is not much of a problem in diagnosis unless a small amount of air is suspected. Then films taken in expiration may be of great value. The real problem in a pneumothorax is to recognize a tension pneumothorax since this requires immediate attention to save the patient's life. Patients have died in the emergency room of many hospitals because tension pneumothorax was not recognized.

When a pneumothorax persists it may be caused by a ruptured bleb. In this case the lung will not expand until the broncho-pleural defect seals over. Meanwhile the collapsed lung may become atelectatic or fluid may collect in the pleural cavity. We have observed cases of 50% pneumothorax or more in which a small catheter is inserted in the pleural cavity, air withdrawn and in a few days the patient is ready to leave the hospital. Other cases have been observed in which the lung will not stay expanded because of a broncho-pleural defect. In some cases, talc is used to produce an adhesive bind between the visceral and parietal pleura, while in others the area of the bleb can be resected.

Pleural effusions should be recognized as fluid and not consolidations since in most cases fluid should be removed if for nothing more than for diagnostic purposes. But if a large amount of fluid collects in the pleural cavity, it not only embarrasses respiration but it compresses the lung on the same side producing atelectasis. If the fluid is not removed, the atelectasis then becomes a problem and two conditions are producing the opacity. No routine procedure should be followed in examining the chest for pleural

effusion. If effusion is suspected then the radiologist should employ any one of several positions to demonstrate the fluid and its extent. In some cases, he must pay attention to the amount of density, absence or presence of air, adhesions, encapsulation or interlobar collections. It is not sufficient to order standard positions of the chest in effusions since fluoroscopy may indicate quite an unusual position of the body to differentiate the difference between fluid and consolidation or both. A marked density along the lateral chest wall may not even be fluid but a primary or secondary tumor of the pleura in which case rib studies may be very enlightening.

Atelectasis is not a primary pathological process but a secondary mechanical condition. For this reason atelectasis must be recognized from the start and not confused with some other type of pathology that causes consolidation. It is well to try to classify it as intrinsic, extrinsic or extra-pulmonary so that corrective measures can be started as soon as possible. If unrecognized the area of atelectasis may become infected with the development of a chronic pneumonitis. Eventually bronchiectasis or abscess formation will develop as a further complication. As previously mentioned, the consolidation present in a bronchogenic carcinoma is mostly atelectasis and not tumor tissue.

Bronchiectasis is a relatively common condition in which the amount of sputum expectorated may be very misleading. The lack of or amount of increase of the broncho-vascular as demonstrated on a film can also be misleading. The history of previous pathology may be of great importance if it is kept in mind that bronchiectasis is the sequelæ of former acute or chronic lung conditions. If not recognized it will continue to be a source of infection, may spread to a larger area or even be the area of the lung subject to repeated acute pulmonary infections. These patients may do better in a climate of low humidity but they are not cured of the infection and only a small percentage can resort to this type of relief or symptoms. The diagnosis of bronchiectasis can only be suggested on films of the chest so that intratracheal injection of an iodized oil is absolutely necessary to arrive at the diagnosis as well as the exact location. We prefer the use of a new product, Dionosil® water soluble, to the other oils since it coats well and disappears from the lung fields in a very short time. This makes it possible to examine one lung at a time within a week. We feel that it is better to examine one side at a time giving us the advantage of oblique and lateral views without superimposition of shadows. It is not enough just to make a diagnosis of bronchiectasis but we should say which lobe is involved or which part of a lobe. This should be done by naming the lobes or parts of lobes by identifying the various bronchi that supply the lobe. The surgeon must know whether a lobectomy with or without the lingula or a complete pneumonectomy will be necessary.

Both lungs should eventually be examined with the opaque material to determine not only the presence of bronchiectasis but the extent, if any, in the other lung. However the presence of bronchiectasis in both lung fields does not mean that the patient is not a candidate for surgical correction. A few months ago an elderly person was referred for bronchograms because of very foul smelling copious sputum. The films revealed extensive cystic bronchiectasis on the one side and moderate bronchiectasis on the other side. The lung on the side of the cystic bronchiectasis was completely removed with reduction of the amount of sputum 75 per cent and a patient no longer exuded an offensive odor. This illustrated a patient who was told many times that nothing could be done yet no bronchogram was ever done.

The proper evaluation of chest films following thoracic surgery can become a daily problem. These films are for the most part taken at the bedside so are much harder to evaluate than those taken under routine procedure. Daily films are many times necessary from the day of surgery to a week or more later.

Since in many cases we are not alerted as to the type of lung surgery, interpretation may be difficult. We are primarily interested in a residual pneumothorax the first few days then the collection of an effusion in lobectomies. At this early stage we must be on the alert for atelectasis in the unresected portion of a lung and mediastinal displacement. Another complication may arise such as over-expansion of the opposite lung producing herniation of the normal lung toward the operative side.

The evaluation of the operative chest months later is also important. It may be difficult if a

phrenic crush has been done or if fluid has been allowed to collect producing marked thickening of the pleura in the area of the resected lobe. A resected rib may be the only clue that a lobe or part of a lobe has been removed. There may be no pleural thickening, clear diaphragm shadow and the non-operative parts of the lung expanded to fill the entire pleural cavity.

The evaluation of the heart by roentgen methods has taken rapid strides in the last few years. We are no longer interested in a mere transverse diameter but are now concerned with chamber enlargement. This has been brought about by the surgeons interested in cardiac surgery. The diagnosis of a certain congenital or acquired lesion of the heart must be as accurate as possible before a decision can be made as to whether surgery will benefit the patient. In some cases this requires special equipment and a well trained experienced team of physicians. In many acquired lesions, simple roentgen procedures may help the team to determine whether the lesion is amenable to surgery. If we are to help these people with acquired lesions we must attempt accurate diagnosis before irreparable damage has been done to the myocardium.

In conclusion I wish to remind the assembly that patients come to us for diagnosis and treatment. They are being better educated daily as to what methods are available to better arrive at a diagnosis. The patient soon will not be satisfied with the diagnosis of asthma or virus pneumonia without a thorough study of the chest by roentgen methods. Since the prime purpose is to benefit the patient then any information that the referring doctor knows about the patient should be given to the radiologist. He should be your consultant, not a competitor when a diagnosis on your patient is at stake. Do not play a hand of poker with the patient caught in between.

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Changes in psychiatry

American teaching of psychiatry is based upon the recognition that psychiatry has progressed beyond interest in the abnormal human only and is now interested also in the average man and how he relates to his total environment. One fairly acceptable definition states that psychiatry is the study of interpersonal relationships. This is a broad approach which recognizes the value of study of ordinary people so that we may understand their everyday difficulties and anxieties. However, it should be made clear that modern psychiatry, with its roots in the discovery of unconscious dynamics, does not compete with other approaches such as those of sociology or anthropolgy, but rather is complementary to them. Such is the approach to psychiatric teaching now spreading throughout the U.S. Integration of medical teaching is the obvious answer so that the doctor can see his patient as an integrated being and not as a collection of systems; as a sick person, and not as a medical case, surgery case, or psychiatry case. Integration of psychiatry with medical teaching did not come without a struggle in the United States and the process is far from complete even though well in advance of many current British practices. The movement really gained momentum only after the second world war and it is well described by Lidz: "It is the recognition that the two heritages, the biologic and the cultural, are inextricably interwoven and can only be separated artificially that has brought psychiatry back into the main stream of medicine." *John A. Ewing, M.D. The Role of Psychiatry in Medical Education. Brit. M.J. Sept.* 1, 1956.

Middle Third Facial Fractures

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In two wars fought in the past decade, all varieties of bone injuries have been encountered, from more or less clean penetrating wounds to tearing away of great masses of bone and soft tissues. Comparable injuries are encountered in traumatism wrought by civilian pursuits, industrial and traffic accidents, mass catastrophes, and in malignant and neoplastic diseases.

The maxilla is vulnerable to trauma because of its exposed position and its close relationship to the base of the skull, orbits, orbital nerve, nasal fossae, and maxillary sinus. The maxillary bones, considered surgically, include the malar, palate, inferior turbinate, lacrimal, nasal, lateral masses of the ethmoid, and nasal septum.

Fractures and displacements of bone fragments of the maxilla are caused by force, violence, and gravity: (1) by force applied from the front in an upward and backward direction, producing a backward displacement toward the base of the cranium; this produces more or less comminution and impaction, and (2) by force applied to either side, when the malar bone is driven into the maxillary sinus with varying numbers of radiating fractures.

It is the author's purpose to describe the various types and sites of fractures encountered in injuries to the middle third of the face. Methods and techniques employed by the author in the treatment of these various types of maxillary fractures will be discussed, with emphasis on prompt definitive reduction and restoration of function, as early as the patient's condition permits.

ANATOMY

Two maxillae unite to form the upper jaw, each consisting of a body connected by four projections: the zygomatic, alveolar, frontal, and palatine processes. The maxilla is irregular in shape and its hollow interior forms the maxillary sinus. The orbit, nasal fossae, and oral cavities are partially made up by the maxilla.

The maxilla is connected to the skull by a series of buttresses, as described by Cryer.[1] These buttresses may be divided into three groups, situated above, laterally, and posteriorly; above by the lateral walls of the interorbital space. This space is confined laterally by the medial walls of the orbit; anteriorly by the nasal process of the frontal bone, frontal processes of the maxilla, and the nasal bones, and posteriorly by the body of the sphenoid. In this space are found the ethmoidal air cells, upper part of the nasal fossae, and lacrimal apparatus. The cribriform plate and roof of the ethmoid sinuses separate the interorbital space from the anterior fossa of the skull. In injuries producing impaction of the maxilla or nasal bones into the interorbital space, dural lacerations and brain damage may result because of this close association. Laterally the maxilla is buttressed by the zygomatic bones connecting the maxilla to the skull. The outer half of the floor of the orbit is formed by the zygoma. The pterygoid processes of the sphenoid bone attach the maxilla to the skull.

DIAGNOSIS

In injuries of the maxillofacial region, damage to the superficial soft parts will be obvious from inspection and from a history surrounding the accident. The facial bones are next investigated. They lie immediately below the skin and permit palpation if the injury is seen shortly after the accident. However, if time has intervened, swelling, hematoma, and emphysema will obscure the physical findings. Significant symptoms of fractures are epistaxis, emphysema, subconjunctival hemorrhage, pain, diplopia, and mobility of the affected parts. Roentgenograms should be made in special positions.

Diagnosis often is made by palpating the infraorbital margins. A notch will be noted at the junction of the zygomatic bone and maxilla. The zygomatic arch or zygoma, if fractured, may press on the coronoid, limiting its motion.

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The author, in a previous publication,[2] listed the complications arising from fracture of the malar bone and zygomatic arch as enumerated by Gillies, Kilner and Stone[3] such as nerve and eyeball injuries, involvement of the antrum or nose, suppurating hematoma of the antrum, and mechanical obstruction of jaw movements by impingement of the zygoma on the coronoid process.

Roentgenograms are necessary to determine the direction of the fracture line and facial bones involved. Interpretation of roentgenograms of the facial bones is difficult, however, because of over and underlying structures and our inability to standardize the technique. Diagnosis of maxillary fractures also is difficult because a continuous fracture line is never seen. Fractures are to be looked for at the rim of the orbit, frontomalar suture, frontonasal suture, and zygomatic arch. Two roentgenograms should be made at right angles, for the diagnosis of any fracture. Each particular fracture will require a certain view to demonstrate the break. The structures to be identified and outlined when viewing the plates are the orbits, malar bone, zygomatic arches, nasal processes, antrum walls, cervical vertebrae, the mandibular body, the ramus, coronoid, and condyle.

In addition to plates made for diagnosis, other roentgenograms should be made from time to time from the same angle and with the same technique. The first additional roentgenogram is made immediately after reduction and others at regular intervals thereafter, to detect any relapses that may occur. Obliteration of the fracture line will not occur for a period of six to 12 months or longer. Bone absorption will be evidenced by a widening of the fracture line but bone absorption from infection will not be evidenced for a minimum of 14 days. Sequestria will be evidenced by decalcification of living bone, while dead bone retains the initial density. This same phenomenon is seen in comminuted fractures, when fragments have not remained viable. Nonunion will be noted by a rounding of the fragment edges and development of cortical bone over the ends.

Roentgenograms necessary for demonstrating maxillary fractures are the occipitomental and lateral projections. The occipitomental projection will demonstrate the orbital margins, antra, nose, coronoid processes, and malars. The chin is placed upon the plate with the external occipital protuberance vertically above it. The lateral projection will show the upper jaw and facial bones. It is accomplished by placing the head sideways upon the plate, with one ear vertically above the one resting on the plate.

GENERAL PREOPERATIVE CARE

Traumatism resulting in facial damage of varying degrees requires an appraisal of the patient's general condition. Our first concern is control of hemorrhage and shock, protection of the wound from further injury, and relief of pain. Until shock has been relieved, cleansing and debridement, suture of soft parts, or reduction of fractures should be postponed. The only exception is control of massive bleeding occurring concurrently — a serious potential in facial injuries.

Routine preoperative preparation for treatment of fractures in the facial region are the same as for injuries elsewhere in the body.

ANESTHESIA

The author employs either block or infiltration anesthesia whenever practicable. Local anesthesia is not used in operations for reduction of facial fractures if the operator, by its use, is hindered in the performance of surgery. In any operative procedure about the nose and mouth, light preoperative medication is administered to prevent hampering of the respiratory efforts. Intravenous and rectal anesthetic agents are avoided, limiting our choice to nitrous oxide, oxygen, and ether vapors. Inhalation endotracheal administration is the simplest method since this equipment is least complicated and with it an adequate airway is maintained throughout operation.

In the majority of patients, intubation blindly through the nose is possible, after the preliminary induction. The tube is ushered into the nose and poised just above the larynx, as determined by the maximum breathing through the tube. On the next inhalation it is thrust quickly but gently farther on. The McGill tube is in the trachea if air and breath sounds come from the tube. The pharynx is then snugly packed. When the operation involves the middle face, nose, and eyes, the tube is inserted through the mouth. The McGill tube is introduced by using a laryngoscope, and the tube is inserted under direct vision. The pharynx is then packed

off. Success of the endotracheal method depends largely upon the quality of the connections and caliber of the tubes. When electrosurgery or coagulation is to be used, the machine is emptied of ether and the patient carried on nitrous oxide and oxygen during this period.

The skill of the anesthetist in this type of operative procedure is quickly demonstrated, and his experience in anesthetizing a patient for head and neck surgery, is evidenced by his willingness and ability to get away from the operating field, and thus avoid interference with the operator's accessibility to it. Sadove[4] believes that the choice of anesthetic agent, in most instances, is given more importance than is justifiable. In his opinion, the anesthesia depends largely upon the ability and experience of the individual anesthetist.

When a patient requires extensive repairs involving many stages of operative procedures, it is essential that each induction and recovery be as pleasant and safe as possible. The endotracheal tube, with complete occlusion of the pharynx, represents the maximum of safety for the patient and convenience for the operator. It enables the anesthetist and his apparatus to be well away from the field of operation. Such anesthesia, however, is not always available, requiring as it does, special apparatus and skill.

There are certain dangers with other types of anesthesia in head and neck surgery, such as inhalation of infected and foreign material, and precautions must be taken during operations upon the mouth, such as placing a gauze pack between the palate and dorsum of the tongue.

Many procedures, such as application of wire, are better performed without anesthesia. However, anesthetics are indicated for operations upon the fracture areas when force may be applied.

To insure an adequate airway postoperatively, a short McGill tube is passed through the nose, until the patient is completely awake. As an added precaution, we turn the patient on his side or abdomen, with the head turned, in order that drainage may run from the mouth by gravity, rather than to depend upon suction to clear the throat of any blood or debris.

TREATMENT

It should be emphasized that early continued mobilization for all fractures is necessary. The fragments should be immobilized in such apposition that when united, full, or at least the best possible function is restored. Simple fractures also should be treated by immobilization in the correct position. A great proportion of fractures of the face are compound and may be infected but as the infection is superficial the body immunity will care for it. Drainage may become necessary in certain fractures and should be provided if suppuration occurs.

In comminuted fractures, each fragment is the potential center for osteoid tissue formation. Therefore, no fragment should be removed that has a chance of viability, and only those pieces are removed which are completely detached.

Foreign bodies of any description between fragments will produce either delayed or nonunion and must be removed. In soft tissues they are less harmful and the tissues will tolerate small fragments of a metallic nature. Removal of glass, ground-in dirt, and foreign bodies and general aseptic care must be accomplished to meet the needs of each patient and the circumstances surrounding the accident.

When a fracture passes through a tooth socket and the tooth is involved in the fracture, death of the pulp tissues is presumed and nonunion will result if the dead tooth is allowed to remain. Retention of a tooth in the line of fracture for a few days will seldom do any harm and there are occasions when early extraction may do more harm than good.

Treatment of the Bony Tissues. Reduction and fixation of maxillary fractures are based upon the available points of fixation peculiar to the specific fracture, rather than the level at which the fracture occurs. Union occurs rapidly in the impacted fracture of the upper jaw and for this reason, reduction must be effected at an early stage. It is only when the patient's general condition does not permit use of an anesthetic, that slow traction is used. Complete reduction of the floater types may be effected by intermaxillary elastic traction or wires, without anesthesia. Adequate fixation for a great proportion of patients is obtained by fixing the upper jaw to the lower and only in the very mobile fracture is it necessary to use external fixation. When the fracture is seen late, it may be necessary to camouflage the deformity by means of reconstructive surgery.

Le Fort[5] in 1901, located the common sites of fractures of the maxilla. In lower maxillary frac-



Figure 1. The three usual bilateral fractures found in fractures of the maxilla.

tures, a single block containing the alveolar process, vault of the palate, and the pterygoid processes are detached.

The various locations of fractures of the middle third of the face follow, with a specific method of treatment for each.

Fracture of the Alveolar Process. The crown of the teeth may be fractured at the level of the gingival margins or forced out of their sockets, the alveolar bone may be comminuted, and affected teeth devitalized. The palate usually is not involved, because this injury, as a rule, is associated with lacerating or contusing wounds. The most difficult displacement is when the alveolus has been driven and impacted into the maxillary antrum. If this is not reducible, surgical intervention is indicated.

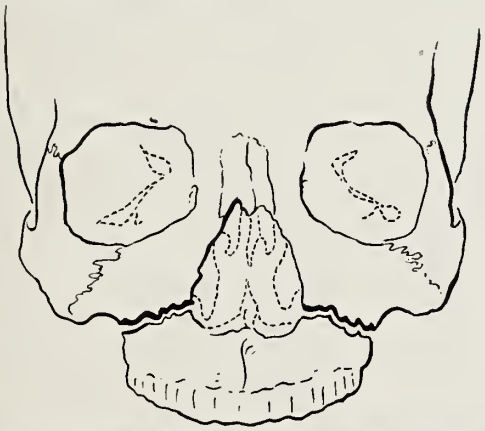


Figure 2. Transverse fracture involving palate and lower portion of the maxilla.

When the aveolus is not displaced, it is sufficient to fix the fragment with the use of buccal arch bars, immobilizing the fragment for a period of 30 days. This fixation can be applied to fractures of either the upper or lower alveolar jaw.

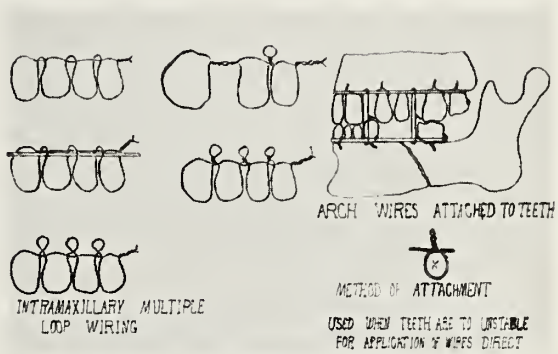


Figure 3

Fractures in which the line of fracture assumes a horizontal course and involves only the alveolar process, are treated according to the relation of the line of fracture to the roots of the teeth. If the fracture passes across the occlusal or incisal half of the dental roots, no treatment is required and the teeth may be retained. When the fracture line is close to the apices of the dental roots there is danger of pulp necrosis owing to disturbance or shutoff of the blood supply.

Horizontal Maxillary Fracture. In the complete transverse fracture, there is separation of lower maxillary fragment from the rest of the maxilla, as in Fig. 2. Displacement of the fragments may be downward and, because of the looseness of the fragments, the teeth may be in normal occlusion. Lateral and posterior displacement is not uncommon, with disturbance of occlusion. Impaction or so-called floating fragments may be encountered. Upward displacement usually will be found in the impacted fragment.

When the fragment is displaced downward,

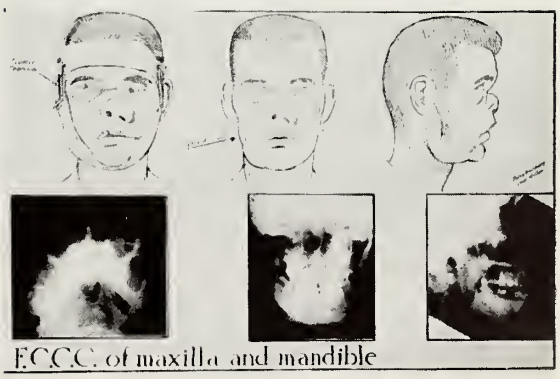


Figure 4

the maxilla is generally loose and palpation and manipulation will demonstrate the fracture line. Intermaxillary multiple loop elastic traction will hold the fragment in normal anterior-posterior position and occlusion, as in Fig. 3. Upward pressure will be required to maintain the fragments in apposition. This may be accomplished with a modified Barton's bandage with a few elastic bands supported by safety pins. These fractures heal rapidly and union is accomplished within 14 to 21 days.

Lateral, downward, and backward displacement is a more serious fracture, involving the nasal and zygomatic bones. The line of fracture, here, extends through the root of the nose, the floor of the orbits, and down and back through the pterygoid processes and sphenoid bones. Reduction is accomplished by bringing the upper and lower teeth into occlusion. Elastic traction applied to the teeth by means of an arch bar or multiple loop intermaxillary traction, will bring the fragments into place in a reasonably short time, with little discomfort to the patient. Gravity is counteracted after occlusion is accomplished with a modified Barton's bandage, with elastic bands placed in front of the ears. If there are soft tissue lacerations or lack of teeth in either the upper or lower jaw, a Kingsley splint may be used, for the upward pressure necessary to offset the pull of gravity on the soft tissues. As in fractures, when the fragment is displaeed downward, fixation of 14 to 21 days usually results in consolidation.

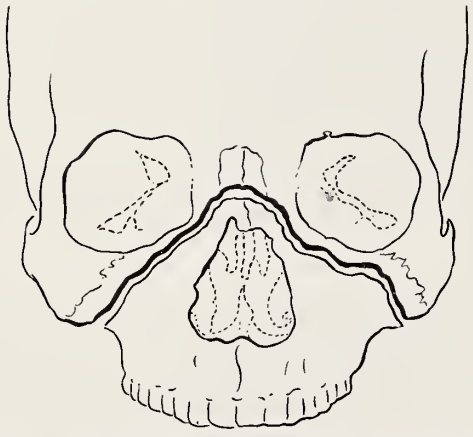


Figure 5. The line of fracture here, extends through the root of the nose, the floor of the orbits, and down and back through the pterygoid processes and sphenoid bones.

Fracture of the middle portion of the face may involve the frontal bone, ethmoidal and frontal sinuses, bones of the interorbital space, the cribriform plate, and frontal lobe of the brain.

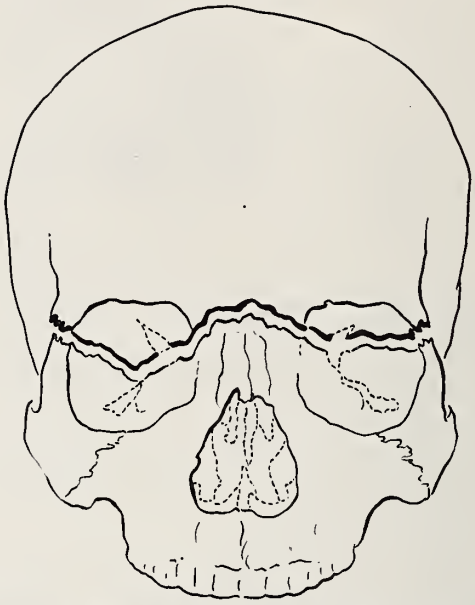


Figure 6. Fracture of the middle portion of the face may involve the frontal bone, ethmoidal and frontal sinuses, bones of the interorbital space, the cribriform plate, and frontal lobe of the brain.

Fracture of the Zygomatic Bone. Fractures of the zygomatic bone often are unrecognized because of swelling in the soft tissue and, if the displacement is only moderate, slight flattening of the cheek results. Diplopia with severe displacement and restriction of the mandible results, when the zygomatic bone displacement is downward. Diplopia may be caused by temporary swelling of the soft parts or by damage to Tenon's capsule, if of a permanent type. The maxillary sinus may be filled with blood from injury to the mucosa, and in comminuted fractures, bony spicules, debris, and foreign bodies of all types may be found.

Treatment may be accomplished by any one of several methods. The intraoral approach is performed by incision made in the buccal mucosa above the tuberosity of the maxilla on the affected side, and an elevator is passed up behind the malar bone. The bone is then elevated upward and outward. On reduction, the operator will experience a definite give when the bone enters into position.

A temporal approach described by Gillies and associates is made through an incision in the

scalp about 2 centimeters in length through the temporal fascia. The space between the temporal fascia and temporal muscle, leads directly under the zygomatic arch, to the medial surface of the bone. A long flat elevator is inserted and by means of leverage, with the instrument resting on the posterior margin of the scalp incision and the skull, the zygomatic bone is elevated into the original position.

Comminuted Fracture of the Zygoma. In comminuted fracture of the zygomaticus, the maxillary sinus must be evacuated of bone splinters and support must be provided. The sinus is opened through a Cauldwell Luc incision. The

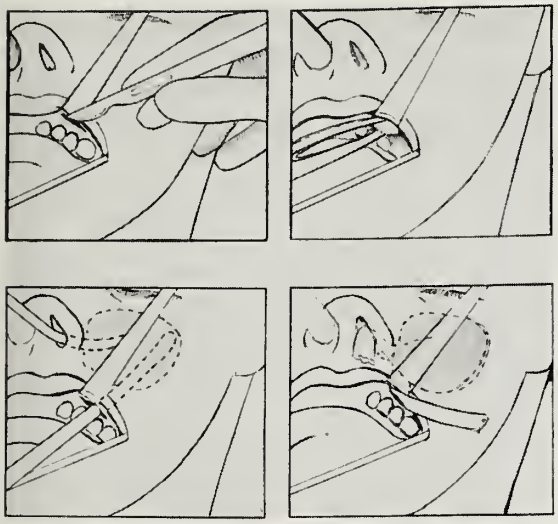


Figure 7. In comminuted fracture of the zygomaticus, the maxillary sinus must be evacuated of bone splinters, and support must be provided. The sinus is opened through a Cauldwell Luc incision.

sinus is explored, removing the bony spicules and hematoma. The displaced fragments are then manipulated into position. After the maxillary sinus is evacuated and the fragments are in position, support becomes necessary to hold them in place. If it is desired to close the mouth opening into the sinus, the packing may be brought out through an opening under the inferior turbinate of the affected side. However, the author prefers to bring the pack out through the oral opening. The cavity of the sinus is packed in slight overcorrection with iodoform gauze, with most of the iodoform washed out in sterile water. The packing is left for a period of approximately seven to 10 days, when it is removed from the sinus either through the mouth or through a nasal opening under the inferior turbinate. The author has observed no complications from allowing the packing to remain in the antrum, provided the cavity of the antrum has been freed of any extraneous material.

Compound Comminuated Fracture of the Zygomaticus. In this condition there are always associated soft tissue injuries and immediate treatment requires removal of all foreign bodies, debris, and devitalized hard and soft tissues. The fracture is then cared for in the same manner as described for comminuted fractures.

Unilateral Fracture. Unilateral fractures, in which displacement is minimal, may be reduced manually and immobilization is produced by intermaxillary wiring or the placement of a buccal arch bar, plus intermaxillary wiring, as in Fig. 3. A splint may be made from one of the hydrocolloids and attached with a divided button. With this type of splint, intermaxillary fixation is unnecessary but immobilization for 28 to 35 days is required.

Unilateral fracture with considerable displacement, as a rule, can, be reduced and immobilized by a lateral pull applied to an arch bar attached to the loose fragment. On lateral displacement, the loose fragment will be displaced downward resulting in an open bite. This may be corrected by some form of intermaxillary wiring. The most satisfactory result is accomplished by placing a buccal arch bar on the lower teeth and applying elastic traction between the upper and lower teeth, correcting the downward displacement. When the loose fragment is replaced for a day or two, the elastic bands are then applied between the upper and lower jaw, and held in place for a period of four to five weeks.

Transverse Fracture. Fracture of the maxillary bones varies from injuries to the alveolar process to tearing loose of all of the facial bones by a transverse fracture at or near their attachment to the cranium, as in Figs. 1. and 6. They often are associated with extensive fracture of the brain case and brain injury. Transverse fractures usually are compound. A transverse fracture may occur through the middle portion of the nasal bones, extend through the frontal processes of the maxilla, and produce backward displacement of the maxilla and nasal bones in the lower portion. In this type of fracture, when complete, the bony framework below the fracture will sag, owing to pull of gravity. The maxilla

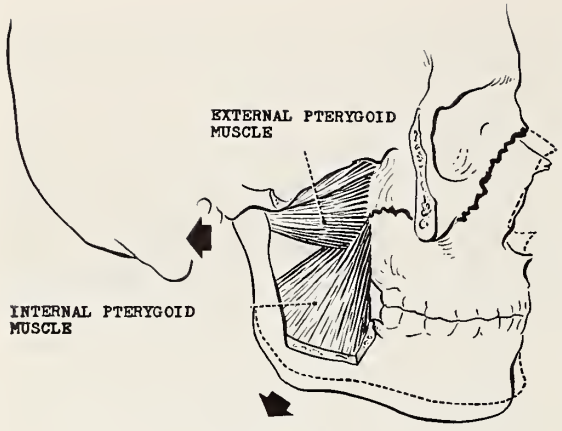


Figure 8

supports only the muscles of expression and for this reason, there is less displacement in bones with heavy muscular attachment. It is in the transverse facial fracture that basal fractures are most likely to occur. There are instances when the entire face can be seen to move on the cranium by applying force upon the teeth.

Craniofacial Disjunction. The pyramidal process of the maxilla and zygoma may remain attached to the maxilla and the middle portion of the face may be completely detached from the skull. This type of fracture is known as a craniofacial disjunction, as in Figs. 4 and 6.

Treatment requires neurosurgery for brain damage and rhinorrhea. Cranial injury should assume priority because of possible complications. After neurosurgery, the fracture will be manipulated into positon, and reduced as for other fractures in the middle third of the face.

Cairns[6] in 1937, described three methods by which the dura is injured, with resultant rhinorrhea: (1) Depressed fractures of the posterior wall of the frontal sinuses may cause tearing of the dura and penetration of the frontal lobe of the brain; (2) The cribriform plate may be involved by the lines of fracture of the perpendicular plate of the ethmoid; and (3) Fractures involving the middle portion of the face, in which the middle portion is completely detached from the skull and pushed upward and backward, produce rhinorrhea by impaction and comminution of the interorbital space.

Clear fluid from the nose is indicative of this fracture, and may be differentiated from mucus by the staining produced by mucus on a handkerchief. In some patients, this may clear up in a few days but in others the dura fails to heal. Meningitis is a constant threat, and manipulation may not only increase this threat but also the possibility of further tearing or brain damage. Comminuted fracture of this type may be responsible for resulting brain abscesses by the entrance of bony spicules into the brain substance.

Fracture of the Lacrimal Apparatus. Because of its location, the lacrimal apparatus is vulnerable to injuries, owing to bony compression and scar formation. Strictures thus produced require operative intervention for the re-establishment of drainage into the nose by decryocystorhinostomy.

Edentulous upper jaws present a problem in fixation. Slight displacement of the upper jaw is unimportant and merely calls for a new denture. In fracture of bones of the middle third of the face, an upper vulcanite plate is made and wired to the upper jaw and treated as though a full complement of teeth was present.

In backward and upward displacement, in which considerable impaction is present, overhead traction attached to the maxilla, may be necessary for reduction. Weight traction, when required, is accomplished by threading a wire through the alveolus and attaching this to a cord passing over two pulleys of a balkan frame. The direction of pull can be altered by sliding the pulley along the beam of the frame. This will permit the patient to sit up or lie down, as necessary for comfort and rest. If the fracture is mobile, one to two pounds of weight will be necessary; late fractures will require up to six pounds, depending upon the degree of consolidation prior to traction.

COMPLICATIONS

Infection in fractures is rare and diplopia may be a temporary condition. However, late complications may be encountered such as impingement of the coronoid upon the zygomatic arch, permanent diplopia, and flattening of the zygomaticus, owing to incomplete reduction. Impingement of the coronoid may be relieved by removal of the coronoid through the mouth, as previously described by Lewis. Flattening of the face may require osteotomy or build-up with replacement tissue.Diplopia requires the wearing of prisms or repositioning of the orbit by bone grafts in the involved area.

Sequestra are best diagnosed by a blunt probe. They are demonstrated by the characteristic rough feeling of bare bone as the probe is carried across the surface. Presence of a persistent sinus is indicative of infection, dead bone in the fracture, a foreign body, or an infected tooth. When the cause has been ascertained and removed, the sinus will close rapidly, and spontaneously.

SOFT TISSUES

When soft tissue injuries are seen early, suturing may be possible and healing by first intention accomplished, when there is no tissue loss. Radical excision of tissue is to be discouraged because of lack of any excess tissue in the facial region. Under anesthesia, torn, crushed, and devitalized tissues are pared away and the wound explored for dirt and foreign bodies. If sufficient tissue is lost to make tension on the sutures, it is best packed open and allowed to granulate.

When the wound is seen beyond the stage when primary suturing and care can be administered, the wound is packed lightly with petrolatum impregnated gauze, alternated with wet saline or boric acid dressings, changed at 24 hour intervals. Penetrating lesions, as found in gunshot and stab wounds, are best left open to permit slough and infection to drain out.

When there is loss of soft tissue, it is best to suture the skin to the mucous membrane, covering any exposed bone.

MOUTH HYGIENE

The patient with a fractured jaw, rapidly exhibits a foul dirty mouth, owing to interruption of the normal cleansing action of the tongue and cheek movements. Initial cleansing may have to be performed by swabbing or by the manipulations of the patient's own finger. Cleansing the mouth frequently, with the use of the ordinary commercial type tooth paste, has been found most effective. The author has been unimpressed by the cleansing action of the various mouth washes, regardless of elaborate advertising claims,

In the therapy of fractures, antibiotics and the sulfonamides are used only for their definite indications: pain, tenderness, elevation of temperature, and signs of infection.

Roentgenographic evidence of the formation of radiopaque callus does not occur for many months. Therefore, a fracture, which on clinical examination is found to be completely united, may appear on a roentgenogram to be ununited. This phenomenon is so marked that clinical bony union cannot be determined from the roentgenogram.

COMMENT

The number of bone injuries of the head encountered in our modern mechanized era poses a serious problem to the surgeon, neurosurgeon, and general practitioner. One significant factor influencing the seriousness of these injuries and, as we have been concerned with it here, of fractures of the middle third of the face, is the difficulty of immediate accurate diagnosis because, with the exception of traumatism caused by malignant disease or tumors, they usually are emergencies.

For example, accident patients are often seen, many in the emergency room of a hospital, showing little or no visible evidence of head or facial trauma. A history of the accident and circumstances surrounding it should, and in fact must be, our warning signal that facial fractures or other bone damage, particularly brain injury, may be temporarily clouded and unapparent, owing to shock, unconsciousness, hysteria, asphyxia, and other concomitant injuries or diseases. These bone injuries should be suspected, however, and the patients hospitalized if possible for immediate general care and preliminary examination.

After control of shock, a scrutinizing diagnostic examination and roentgenographic studies should then be made before swelling, emphysema, hematoma, or other conditions set in, which might hamper or interfere with examination and diagnosis. There is, always the danger of massive bleeding in facial injuries, and until this is controlled, diagnostic manipulation or operative intervention for reduction of fractures should be postponed. There are instances however, when profuse bleeding will continue until reduction of the fracture is accomplished.

Nevertheless, it must be re-emphasized, that injuries such as those to the maxilla, should receive proper and prompt definitive treatment at the time of or as early after injury as is safely possible. This is of particular importance in cranial injury. Delay in treatment of bone injuries to the face and head may result in unfortunate sequelae such as deforming scars and impaired function, at times necessitating

one or more operative procedures later. In these instances, we often are faced with unavoidably disappointing cosmetic results or inability to restore complete function.

SUMMARY

Diagnosis, general treatment, surgical anesthesia, and complications in injuries to bones of the facial region are discussed.

Various types and locations of middle third facial fractures are outlined, and a specific operative procedure for the reduction of each is described.

Priority for cranial involvement in injuries to the maxillofacial region region is emphasized because of potential complications, and methods by which the dura is injured are presented.

Soft tissue injuries and mouth hygiene in patients with fractures of the jaw, are also discussed.

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Early leukemia

It is well known that chronic lymphatic leukemia may run a long and practically asymptomatic course. The classic picture of splenomegaly, lymphadenopathy, anemia, and a very high leukocyte count probably is only a late phase in the natural history, but it is this stage of the disease that has received the most study. The pathologic processes at the inception of a disease are always the most interesting, yet there are few clinicopathologic data on chronic leukemia in its early stages. This is probably because the opportunity to observe the course of leukemia before the disease has caused symptoms is necessarily rare. *C. Hougie, M.D. The Early Diagnosis and Natural History of Chronic Lymphatic Leukemia. Ann. Int. Med. July* 1956.

Pilonidal cyst

In surgery of pilonidal sinuses and cysts, the closed method is preferred since a certain percentage of recurrence will be seen no matter what method is used. No wound, wherever made, always heals by first intention. The open method results in painful scars and increased morbidity. An attempt should be made to conserve tissue and treat the wound as a potentially infected one since recurrence is in all likelihood due to a subsequent infection of the wound. Based on these considerations, a method of treatment is reported which has resulted in a high degree of healing by first intention and with a minimal amount of loose tissue, morbidity, and sensitive scarring. *James N. Cianos, M.D. and Joaquin Azpiroz, M.D. A Method of Closure of Pilonidal Sinus and Cyst. Maryland M. J. June* 1956.

Amaurosis Fugax: A Specific Type of Transient Loss of Vision

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TRANSIENT loss of vision in the broad sense may be a symptom of various unrelated conditions such as the retrobulbar neuritis of multiple sclerosis, central angiospastic retinopathy, so-called uremic or eclamptic amaurosis, or migraine. It is a characteristic accompaniment also of the common faint, of the blackout of aviators, of postural hypotension, and of so-called pulseless disease. In association with all of the latter conditions, loss of vision is almost always bilateral and results from a temporarily inadequate supply of blood to the retina secondary to a rather extreme lowering of the cerebral or general systemic blood pressure. Repeated obscurations of vision of short duration occur in some cases of papilledema associated with increased intracranial pressure. These too may be due to momentary reduction of the blood supply to the retina and optic nerve though they often are attributed to intermittent increase in the pressure exerted on the optic chiasm by a dilated third ventricle.

The term, amaurosis fugax, which has been defined by Fisher[1] as "periodic blindness in which the principal derangement is an interruption of the retinal blood flow, usually of one eye only," is used at times interchangeably with the expression "transient loss of vision." However, it is more commonly restricted to "a more limited group of cases in which the reduction of blood supply to the retina results primarily from a local disturbance in the retinal arteries or arterioles and not from a lowering of cerebral or general blood pressure."[2]

Persons with typical amaurosis fugax have recurrent episodes of usually unilateral blindness, either total or involving a certain sector of the visual field, in which loss of vision is instantaneous, persists for only a few seconds or minutes, and terminates almost as rapidly as it commenced. The episodes recur with varying frequency, from several times a day to intervals of a month or more. Occasionally episodes occur in each eye but seldom in both eyes simultaneously. In some instances, after several recurrences, the attacks cease spontaneously. In others, after a varying number of identical attacks, an episode occurs in which blindness persists beyond the usual time and recovery, if any, is incomplete. Ophthalmoscopic examination at this time will reveal ischemic infarction of the retina or ischemic neuroretinopathy.

Presumably, the transient interruption of the retinal blood flow in these cases results from arterial or arteriolar spasm or else from a sudden but temporary or unsustained decrease in the local arterial pressure in the optic nerve and retina. Early recognition of the cause of the spasm or of the transient decrease in blood pressure may permit the institution of appropriate treatment which will reduce the likelihood of permanent blindness.

The stated duration of the periodic episodes of blindness is a distinguishing feature between true amaurosis fugax and superficially similar complaints which are not based upon demonstrable organic disease. Reasoning by analogy from the studies of Gildea and Cobb[3] on the effects of anemia on the cerebral cortical cells of cats, it might be postulated that degeneration of the ganglion cells of the retina will occur if the blood supply is cut off completely for more than five minutes. In recent studies by means of electro-retinograms controlled by electro-encephalograms, Popp[4] determined that the retina of a rabbit can regain its full function after 15 minutes of ischemia and can regain partial function after 30 to 75 minutes of ischemia; evidence of function cannot be elicited after 105 minutes of ischemia. It would seem justifiable, then, to view with suspicion complaints of transient unilateral total or sector blindness with complete recovery in which blind-

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ness is said to persist for more than 15, or at most 30, minutes.

Possible Causes

Migraine: Migraine is listed frequently among the causes. The diagnosis of migraine was made in 24 of 138 cases collected from the literature by Fisher.[1] However, he wrote, "there are but a few unequivocal cases of unilateral blindness associated with migraine." The usual and characteristic episodes of transient loss of vision which occur in patients having migraine would seem to satisfy all criteria necessary for the diagnosis of amaurosis fugax save that of unilaterality and, possibly, of duration. In the typical attack, both eyes are involved simultaneously and the blindness is total or it involves homonymous areas of the visual fields. It is assumed, therefore, that the vasospasm or vasoconstriction involves the blood supply to the occipital cortex. Engel, Ferris and Romano[5] were able to demonstrate electroencephalographic abnormalities which support this assumption. Behrman[6] stated that the disturbance of vision in migraine frequently is uniocular and that when the episode is not followed by complete recovery, "then ophthalmoscopic examination reveals occlusion of one or more branches of the central retinal artery in the absence of any disease of the retinal vessels." Miller[7] has seen two patients in whom obstruction of a branch of the central retinal artery followed an attack of migraine. More usually, however, permanent loss of vision is of homonymous hemianopic type, as in the cases reported by Hollenhorst,[8] if it is residual to a typical attack of migraine. Transient or permanent monocular blindness or sector or scotomatous defects should not be attributed to migraine, however, unless other possible causes have been carefully eliminated.

Spasm Secondary to Local Lesions in the Walls of the Retinal Vessels: Formerly it was thought that spasm of normal retinal arterial vessels could be of primary neurogenic origin through the cervical sympathetic nerves. More recently, however, it has been shown that neither stimulation nor blocking of the cervical sympathetic nerves has any appreciable effect on the retinal arteries or arterioles. It is true that amaurosis fugax rarely occurs among patients having Raynaud's disease or patients who exhibit a generalized peripheral vasospastic tendency. Much more frequently, vasospasm is secondary to an organic lesion in the wall of a vessel. At times, such a lesion can be seen in a retinal arteriole between attacks. If, for example, an atherosclerotic plaque is present, loss of vision will be limited to the sector of the field corresponding to the part of retina which derives its blood supply from the arteriole distal to the plaque. In many cases the presence of a similar lesion in the central artery behind the lamina cribrosa undoubtedly is the cause of blindness that involves the entire field of vision. Since it is impossible to make an unequivocal clinical diagnosis of atherosclerosis of the central artery of the retina, other possible causes of spasm of the artery must be investigated and eliminated before the tentative diagnosis of atherosclerosis is made.

Arterial or arteriolar spasm may occur in the retina as elsewhere secondary to the irritative effect of the temporary lodgment of a nonocclusive embolus. In a previous publication,[2] I noted that chronic endocarditis was present in 14 per cent of a small group of patients having amaurosis fugax but that, because of the inactivity of the cardiac lesions, it seemed doubtful that recurrence of small emboli could account for the episodes of transient loss of vision. It must be remembered, however, that emboli in the retinal arterioles, which can be seen occasionally shortly after an episode, can have their origin also in an atherosclerotic lesion in the central artery itself.

Retinal Arterial Spasm Secondary to a Lesion in the Carotid Artery: It has been demonstrated rather recently that spasm can be induced in a distal branch artery by an irritative lesion in the wall of the proximal larger artery. Ecker and Riemenschneider[9] demonstrated, by means of arteriograms, the occurrence of spastic contraction of adjacent cerebral vessels soon after the rupture of an aneurysm of the circle of Willis. They showed also that spasm of the intracranial branches of the internal carotid artery could be induced by the presence of a needle in the wall of the common carotid artery. Rezende and Martens[10] observed in the dog that spastic constriction of the central artery of the retina occurred after the rapid injection of antibiotic solutions or distilled water into the common carotid artery. However, as the constriction did not occur until the solution had reached the retina (as could

be demonstrated by the addition of methylene blue to the solution), it is not possible to say whether the spasm was induced by irritation of the carotid or of the central retinal artery itself.

In 1951, Behrman[6] postulated that some cases of amaurosis fugax might be explained by the presence of an occluding pathologic process affecting the internal carotid or the ophthalmic artery. In the same year, Fisher[11] called attention to a group of cases in which recurrent episodes of transient monocular blindness preceded the development of contralateral hemiplegia due to spontaneous thrombosis of the internal carotid artery. In 1952, he[1] stated, "Disease of the internal carotid artery will no doubt help to explain at least some of the previously reported cases of amaurosis fugax, particularly in the older age groups." It is generally recognized now that episodes of amaurosis fugax in the homolateral eye may be one of the early symptoms of progressive occlusive disease of the common or internal carotid artery, other manifestations of which are transient episodes of aphasia, contralateral hemiplegia or hemianesthesia, and the like. Episodes of amaurosis fugax had occurred in 15 of 39 cases of occlusive disease of the carotid artery studied by Hollenhorst.[12]

As various manifestations of intermittent insufficiency of the internal carotid system, such as transient blindness, hemiplegia, aphasia, or paresthesia, tend to occur in different episodes rather than all at the same time, it seems probable that they are due to spasm of individual distal branches and not to spasm of the carotid itself or to a temporary drop in arterial pressure. It is true that the blood pressure usually is lower in the branches of the diseased carotid artery than in those of the normal artery of the opposite side as can be demonstrated by dynamometer measurements of the retinal arterial pressures. Thus in all seven cases studied by Millikan, Siekert and Shick[13], the retinal arterial pressure was found to be lower in the eye on the affected side than in the fellow eye. The difference in diastolic pressures amounted to 10 mm. of mercury in one case, 15 mm. in two cases, 20 mm. in two, 22 mm. in one, and 35 mm. in one case. Only one patient, however, gave a history of transient loss of vision. The retinal diastolic pressure in the affected eye was 25 mm. of mercury while in two other patients, neither of whom complained of transient loss of vision, the retinal diastolic pressures were 20 and 22 mm. of mercury, respectively.

Millikan, Siekert and Shick[13] expressed the opinion that the transient neurologic manifestations of intermittent carotid insufficiency are best explained on the basis of embolism. They stated, "Our present concept of the pathogenesis of the attacks is as follows: A thrombus begins to form on an area of diseased endothelium. This soft material may reach a size sufficient to produce enough alteration in blood flow to cause symptoms, break from its source, fragment, and be carried away. More likely, however, appears the possibility that the newly formed clot becomes dislodged before symptoms occur, travels to a place where the vessels branch, lodges for a few minutes (symptoms produced), and then fragments and is carried away." These authors favor long-term anticoagulant treatment in these cases for the prevention of retinal or cerebral infarction. They stated, "Careful inspection of historical and physical data on the patient may well lead to the ability to diagnose a potential infarction and even in certain instances prevent it. With this concept in mind, a diagnosis of intermittent insufficiency of the internal carotid artery has been established in seven instances. The patients were treated by the administration of anticoagulant drugs and the characteristic attacks ceased."

Local Circulatory Insufficiency: The most outstanding examples of the effects of local circulatory insufficiency on the eye are furnished by cases of so-called pulseless disease in which arteritis, usually nonspecific, involves the branches of the aortic arch. However, the visual symptoms of this disease are bilateral and are those of an exaggerated postural hypotension rather than of typical amaurosis fugax. When the patient remains in an upright position for any length of time, the retinal arterial pressure drops practically to zero and fragmentation of the blood stream can be seen in the retinal vessels. The vision is blurred but is not lost completely. In more advanced cases, vascular proliferation takes place in the retina and cataracts develop.

In 1952, I[2] stated, "It is possible that spasm of the retinal arterioles, distal to the region of organic arterial disease, may be a factor in the rapid onset of blindness in some cases of temporal or cranial arteritis. But it is doubtful that typical amaurosis fugax occurs in this disease."

However, a recent review[14] of a rather large series of cases has brought out the fact that transient loss of vision, which would have to be classified as amaurosis fugax, does occur in a significant number of patients who have temporal arteritis. Thus, of 17 patients who had sudden acute permanent loss of vision, seven gave histories of previous episodes of amaurosis fugax. Extreme narrowing of the lumen and, in some instances, thrombosis of the ophthalmic and central retinal arteries have been demonstrated by Cooke and his co-workers[15], by Cardell and Hanley[16], by Kreibig[17], by Heptinstall and his associates,[18] and by Meadows[19]. Judging from their findings, it seems more likely that the episodes of amaurosis fugax are due to intermittent circulatory insufficiency than to arterial spasm. When the lumen is sufficiently compromised by the arteritic process itself or by terminal thrombosis, infarction of the optic nerve and permanent loss of vision occur. Cortisone may inhibit the progression of the arteritis and thus prevent permanent loss of vision if treatment is started before visual symptoms are present. Among 33 patients with temporal arteritis who had normal vision on admission to the Mayo Clinic, six complained of transient obscurations of vision. Under cortisone therapy, these attacks ceased and persistent loss of vision did not occur[20].

SUMMARY

Because of the short duration of the episodes, it is seldom possible to make an ophthalmoscopic examination of the affected eye during an attack of transient loss of vision of the fleeting type. Therefore, the diagnosis of amaurosis fugax must be made primarily on the basis of the patient's description of the episodes, and the determination of the cause of the syndrome must depend ultimately on the findings of the consulting internist. However, careful study of the ocular fundus between attacks may reveal clews to the origin and nature of the attacks. An atherosclerotic plaque may be visible in a retinal arteriole or the residual of a small nonoccluding embolus; the latter, in the absence of evidence of an active cardiac valvular lesion, may suggest the presence of atherosclerosis either in the central artery of the retina or in the internal or common carotid artery on the side of the involved eye. If the fundi are normal and the patient does not have a history of migraine or Raynaud's disease or a Raynaud-like syndrome, search should be made for possible signs and symptoms of a localized lesion in the common or internal carotid artery and for evidences of temporal arteritis. If either diagnosis can be established, institution of proper therapy [anticoagulants in the first case and cortisone in the second] may prevent permanent loss of vision and, possibly, involvement of other parts of the nervous system. It must be admitted, however, that in spite of careful study of the patients, the cause of amaurosis fugax in some cases will remain undiscovered.

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Intra-Articular Hydrocortisone in Office Practice

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MANY of us have been disappointed in the systematic use of ACTH, cortisone, and hydrocortisone in rheumatic disorders because of the danger of serious side effects, the exacerbation of symptoms when the hormone is stopped, and the expense of treatment. Locally injected hydrocortisone has been found to be ideally suited to the treatment of these disorders because it has none of these disadvantages. In addition it has been found to be effective in a wide variety of other conditions of joints, bursae, and tendon sheaths. The underlying pathological similarity of all these conditions is sterile synovial inflammation.

Hydrocortisone for intra-articular injection was first brought to our attention by J. L. Hollander[1] when he reported using it in 129 patients afflicted with bursitis of the shoulder and various other acute and chronic rheumatic and traumatic joint conditions. We began using hydrocortisone acetate in early 1952 and soon found after reviewing 100 cases of injected shoulders and knees, that we could get good results in 85 per cent. My associate and I have now injected it over 1,000 times, mostly in shoulders and knees, in our orthopedic office practice and note that Hollander has injected it 17,000 times in his University Arthritic Clinic.

Hydrocortisone (compound F) is closely related to cortisone (compound E), differing only in having an OH group substituted for the O at carbon position 11; its chemical name is 17-hydroxycorticosterone. The acetate salt is only slightly soluble in saline or joint fluid, and is slowly absorbed into the general circulation after injection. Five cc. vials labeled "Hydrocortisone for intra-articular injection," contain a suspension of hydrocortisone acetate, usually 25 mg. per cc. It has a non-specific anti-inflammatory effect on synovial tissues. By reducing the inflammatory reaction it prevents the inevitable sequel of inflammation, fibrosis, and adhesion formation.

We have used hydrocortisone injections in treating bursitis in many locations, particularly the shoulder; tenosynovitis; sprains, fractures; and various forms of arthritis. We have supplemented it with other standard measures, such as physical therapy, immobilization, and supportive medications. It increases the rate of recovery and even gives relief of pain in some cases after other methods of treatment have failed. The condition for which it was injected usually shows marked improvement within 24 to 48 hours.

As Hollander has pointed out,[1,2] the technique of injection is simple. No gloves or drapes are used. In our office, a simple tray is prepared containing our favorite antiseptic, a local anesthetic, the vial of hydrocortisone for intra-articular injection, two syringes, two needles and cotton swabs. When injecting joints, the needle is placed at the point of election for injecting that particular joint. When injecting bursae and tendon sheaths, we first find the point of maximum tenderness by palpation, and paint a small area with the tender point in the center of the painted area. This may be likened to a target with the center the bull's eye. After painting the target, the tender point may be double checked with the tip of the cotton swab. Novacaine is used in the skin only for bursae, but is infiltrated down to the synovial lining when injecting joints. When injecting tendon sheaths and small joints distention can be felt by the patient and helps to check the placement of the needle. Before injection, X-ray examination is made to aid in diagnosis and rule out contra-indications. Infection must be ruled out clinically and by the roentgenogram.

In the shoulder a typical tender point in chronic bursitis or the chronic stiff shoulder is anterior to the joint. The bicipital groove also

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Figure 1



Figure 2

is frequently tender. In acute bursitis, tenderness is most often along the superior point of the greater tuberosity, laterally or even posteriorly. Occasionally more than one typical tender point is present and it is well to inject both with 12½ mg. of hydrocortisone. The usual single injection dose in the shoulder is 15 mg. (Figure 1). If the tender point is atypical, such as in a scapular location, novacaine rather than hydrocortisone should be used. Post-traumatic shoulders, such as sprains, fractures of the clavicle or humerus, cuff tears, and dislocations, may have the same symptomatology and tender areas as chronic bursitis. After the acute episode and healing time has elapsed, there often is great benefit in the direction of markedly hastened mobilization of the joint by timely hydrocortisone injections. In our practice, about 30 to 50 per cent of such injury cases need and are greatly helped by the injections. It must always be remembered, however, that the injection is only an aid in therapy, and appropriate mobilization exercises, such as pendulum, wall-climbing, or rope-and-pulley, should be prescribed. Re-injection often is necessary after two to four weeks. The acromioclavicular joint sometimes is the site of a painful degenerative arthritis which will respond to the injection.

In the elbow, two common lesions respond to injections of hydrocortisone acetate. One is olecranon bursitis, so-called miner's elbow. In this condition the fluid is aspirated and 10 to 15 mg. of hyrocortisone injected. In many, the fluid will recur and surgery may be necessary. At times complete and permanent cure may result from a single aspiration and injection. In those not cured, surgery may be deferred until time of election and multiple aspirations and injections done to control swelling and pain. In so called tennis-elbow (radio-humeral bursitis), the other common elbow disease, injection is the treatment of choice. The tender spot is subcutaneous, on the lateral epicondyle, at the point of attachment of the common extensor tendon. Fluid is almost never aspirated by the needle. Ten to 15 mg. of hydrocortisone is used. (Figure 2) Stretching exercises, consisting of simultaneous extension of the elbow, pronation of the forearm and flexion of the wrist also may be used but usually are unnecessary. Pain in acute trauma to the elbow, with hemarthrosis, whether it be a nonsurgical fracture or severe sprain, is greatly relieved from aspiration of the blood and injection with 1 cc. of compound F. A sling or cast should be used until healing has occurred.

In the wrist, ganglia are the most frequent lesions which will respond to the injection. When painful or associated with weakness of grip, the symptom usually is relieved by aspiration of the gelatinous contents of the cyst with a 15 or 18 gauge needle, followed by hydrocortisone injection. The cyst itself usually recurs and may require elective surgery (and then will still recur in 30 per cent of cases). Tenosynovitis of the short extensor and long abductor of the thumb (deQuervain's disease), occurring at the wrist, will get some pain relief at any stage of the process and cure may be expected in the early stage, before fibrosis has occurred, from the injection. Tenosynovitis of the dorsum of the wrist also can be treated. The course of this annoying disease can be shortened from two weeks to a few days. We have not used the drug in wrist fractures and seldom in arthritis of the wrist joint.

In the hand, tenosynovitis of the flexor tendons (trigger-fingers), will get pain relief from



Figure 3



Figure 4

the injection if successful, but the tendon may still snap until surgical treatment has been instituted. Hydrocortisone never should be used in suppurative tenosynovitis. Finger joints can be injected on the lateral side with a 25 gauge needle. This is done in delayed mobilization from trauma and in monoarticular arthritis. Ten mg. are used.

In the case of injection of the hip joint with hydrocortisone, the results often are unsatisfactory, probably because of poor placement of the needle. However, these patients are extremely grateful for relief because they face a major reconstructive operation or change in their pattern of living if the injection treatment is unsuccessful. In injecting the hip joint, the inguinal ligament is located and the femoral artery as it crosses the ligament. Approximately one inch lateral to this point, and one inch below the anterior superior spine of the ilium, the target area is painted (Figure 3). A 22 gauge needle is used to inject novacaine down to the joint. A spinal needle may be necessary to enter the joint itself. The needle usually strikes the femoral head and may have to be withdrawn slightly if injection is difficult. One-and-a-half to two cc. are injected. If relief is obtained, reinjection is indicated when symptoms recur. A less serious illness about the hip which often reponds to hydrocortisone is trochanteric bursitis. This may mimic sciatica in its radiation of pain but is diagnosed by localized tenderness at the superior-posterior tip of the greater trochanter. These cases often are relieved with only one injection. Post-traumic trochanteric bursitis is common after severe bruising in the trochanteric region. Relief of pain and tenderness may be obtained as long as one to two years after the injury.

The knee joint is the most accessible large joint and responds most favorably to hydrocortisone. Injection is especially useful in self-limited conditions such as trauma, attacks of gouty arthritis, and post-operative effusions. In trauma, we do not hesitate to aspirate a bloody effusion and immediately inject hydrocortisone regardless of whether or not fracture is present. In severe trauma, a cast usually is applied with the knee in extension. In less severe trauma, quadriceps exercises and other therapy may be prescribed. Post-operative effusions occurring a week or two after surgery are greatly benefited by aspiration and injection with about 1½ cc. of hydrocortisone. An effusion which is grossly cloudy and painful often represents acute gouty arthritis. Diagnosis may be made with certainty by running a uric acid level on the aspirated fluid. This is elevated even though the blood uric acid may not be. The acute attack usually is over 24 hours after hydrocortisone injection. In rheumatoid arthritis, joint treatment is only part of the general management of the case. If less than two weeks of relief is obtained from injection, we usually do not continue it further. In osteoarthritis with effusion, effusion usually subsides following hydrocortisone injection and relief may be anticipated for up to a number of months. The effusion is approached laterally superior to the patella. Figure 4). If no effusion is present, results tend to be less satisfactory. The retropatellar approach, lateral or medial, is used when no effusion is present. In prepatellar bursitis, which is usually traumatic, hydrocortisone gives excellent results when no infection is present. Baker's cysts of the knee usually will respond but may recur very much like ganglia

TABLE 1

Site	No. of Injections	Diagnoses
Shoulder	17	15 bursitis, 1 sprain, 1 acromioclavicular arthritis.
Knee	13	5 osteoarthritis, 5 traumatic effusions, 1 postoperative effusion, 1 rheumatoid arthritis, and 1 prepatellar bursitis.
Hip	4	2 osteoarthritis, 2 trochanteric bursitis.
Finger joints	2	1 arthritis, 1 posttraumatic swelling and stiffness.
Tendon sheaths	3	1 anterior tibial, 1 dorsum of wrist, (both tenosynovitis) 1 snapping (trigger) finger.
Hand	1	ganglion.
Bunion	1	bursitis.
Heel cord	1	bursitis.
Metatarso-phalangeal joint of the foot	1	arthritis (traumatic).
Elbow	1	radiohumeral bursitis.
Total	44	

of the wrist and eventually require surgical therapy.

In the ankle, traumatic or degenerative arthritis usually will respond. Rheumatoid arthritis also should but results here are less satisfactory than in the knee. The hormone has not been used in ankle sprains. In the foot, bursitis of the achilles' tendon often is acutely painful and can be relieved readily by injection of 10 to 15 mg. It has also been useful in painful calcaneal spurs (policeman's heel)[3] We have not used it for this condition. Acutely inflammed bunions, where there is no evidence of sepsis, respond to injection with 10 to 15 mg. Other joints of the foot usually are not treated with hydrocortisone since they respond favorably to proper footwear. arch supports, strapping, or general measures.

COMPLICATIONS

1. Severe pain, four to six hours after injection. This can be annoying to the surgeon who gets an excited telephone call about 9:00 or 10:00 p.m. About 5 to 10 per cent of cases have this type of reaction, but it does not preclude a good result from the injection. We usually warn every patient that it may occur, and prescribe A.P.C. with codeine, ice bag, and rest for the part.

2. Missing the joint in intra-articular injections is not compatible with a good result from the injection. Two proofs of intra-articular placement of the needle: The best is the ability to aspirate joint fluid; the second is the ease of injecting into large joints when the needle actually is in the joint. The latter "feel" method is gained by experience. No harm comes from missing the joint cavity except lack of a good result.

3. Infections following injection. We have not in our cases identified any case of infection due to hydrocortisone injection. We note also that Hollander has had only four cases of septic arthritis in his 17,000 injections.[2] We do not believe that the danger of causing sepsis is a contraindication to using this drug.

RESULTS

Since early 1952, my associate and I have injected hydrocortisone over 1,000 times. Several times we analyzed our results and found that distinctly good results were obtained from 85 per cent of the injections. The outcome tends to be better in ostcoarthritis than in rheumatoid arthritis because the duration of relief is longer. Anatomically, results are best in the knee and shoulder and worst in the hip, the latter averaging 50 per cent or less good results. In self-limited afflictions, complete cure at an accelerated rate is the expected result.

Our current usage of hydrocortisone is best illustrated by a table of anatomical sites injected, the reason for the injection, and the number of injections during one recent month. Table 1.

SUMMARY

In our hands, hydrocortisone for intra-articular injection has been found to be a useful adjunct in the treatment of extremity disabilities.

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The Bush Flight Surgeon's Problems

George Bradley McNeely, B.S., M.D., Bloomington

MOST people have been aware of the so-called bush pilot for many years but I wonder if they have ever heard of a bush flight surgeon? As all of you know the bush pilot does everything and anything he can with his airplane. Many of these men earn their living through flying but some fly for convenience due to the long distances of the country they live in.

The bush flight surgeon takes care of class II and III pilots — that is, student, private, and commercial pilots, in contrast to the flight surgeon who examines for class I, or airline transport pilots. The greatest difference, however, is that the bush flight surgeon also is the family physician of the pilot and his family. He treats them surgically, medically and obstetrically.

I would like to present a short account of my aviation medical practice as a bush flight surgeon. At present I have 214 pilots, 165 of whom fly commercially and 49 privately. The youngest is 17, the oldest 62, and the average age is 29. Their certified flying time is from 1 to 7,800 hours and the total for 214 pilots is 741,147 hours. These pilots are farmers, flight instructors, airplane mechanics, radio testers, factory workers, building contractors, attorneys, dentists, doctors, car dealers, insurance salesman and examiners, truck drivers, crop dusters, bartenders, telegraph operators, civil engineers, feed company operators, lime stone spreaders, drainage contractors, policemen, firemen, railroaders, racer drivers, plumbers, bakers, gas station attendants, laundrymen. motion picture operators, real estate salesmen and accountants. The majority are flying farmers.

What are flying farmers? The following newspaper article from the Pantagraph, Bloomington, Illinois, July 28, 1955, best answers this question.

"15 Planes Ready for Trips Over Tazewell Farms.

"Fifteen airplanes have been lined up for the second annual soil conservation airlift scheduled all day Sunday at the airport 2 miles north of Pekin on Fifth Street. The big event, sponsored by the Tazewell County Soil Conservation District, is receiving the assistance of the Soil Conservation Service technicians who have mapped the flights over farms where there are real sights to reveal the latest methods in soil care.

"The Pekin Air Service, flying farmers, and local business men are assisting in the project, the flights to be given at cost, each passenger to be given a chart of the flight he selects and the things to look for as his pilot points them out. Numerous ponds and lakes will be seen, many of them east of Pekin, many others around Morton, according to the flight charts prepared by the S.C.S. technicians. Paul Affolter, Paul Coon, and Norvill Barnes, members of the county staff that assists farmers with conservation problems, have reported good progress the past season.

"The grand total of those farm ponds and lakes now stands at about 100 for the county, many of them encouraged by past years of dry weather and dry wells. Last year 28 new farm ponds were constructed by building dams across big gullies or small valleys. This year attention turns more to the contouring and terracing for there has been less worry about the water sup-

ply. Still many of those farm ponds in southern Tazewell County are only partially filled.

"About 12 miles of new terraces were constructed this year. More and more countouring appears in the landscape. There are many of those waterways that close gullies or keep gullies from forming. Many concrete dams and toe-walls have been built. About 25,000 trees were set out last spring on land hardly suitable for grain crops. Production of Christmas trees has been increased greatly. Recently the Jaycees bought a bunch of Christmas trees five years old, for delivery next December — trees grown from seedlings set out in 1950."

Several of my pilots live elsewhere such as Washington, D.C., Texas, and California. They fly into our local airport for their pilot examinations.

Of the 214 pilots, eight have had accidents over a period of 15 years. None has resulted in death. The majority were crop dusting when the accident occurred. The experience of Pilot J.B.P., with 1,400 hours flying time, is typical. While crop spraying he stalled on a turn at the end of his run. His aircraft was a total loss but his only injuries were laceration of the scalp and dislocation of a cervical vertebra. He returned to crop spraying two days later, and has been flying without difficulty since that time.

I have several father and son pilots, and in one family the father, mother, two sons, and a daughter are all pilots. Of the 214 pilots, 210 are married with a total of 131 children. Seven pilots derive their total income from flying and of these three are on active duty with the air force. Ten pilots own their own planes and the remainder rent or borrow.

My office consists of 12 rooms with seven examining rooms. I have 50 milli amp X-ray and fluoroscope, direct writing electrocardiograph, and a complete laboratory that can accomplish complete blood chemistry and all general laboratory work. I have a 20 foot eye lane, furnished with a phorometer trial frame, multiple Maddox rods, rotary prisms, and corrective trial lenses; a Howard Dolman depth perception apparatus, a blackboard with meridian lines; and a trial frame with a red lense. I have a large eye test cabinet at the end of the eye lane. This consists of 20/200, 20/100, 20/70, 20/40, 20/30, 20/20, 20/15, and 20/10 letters and color spots of aviation red, blue and green. A 20 foot spot of light in incorporated into the cabinet, and all switches are controlled at the head of the eye lane.

The average time taken for a commercial flight physical is approximately sixty minutes. As might be expected, the eyes are the greatest physical problem with these pilots, particularly accommodation. I have several pilots with tri and quadra-focal lenses. Visual acuity is not as great a problem as might be expected. Remember we live in the heart of the corn belt and there are not as many eye irritants or strain in clear air. Also, our sunlight is softened by the predominance of soft green corn and not the hard reflection encountered in deserts and water country.

I am just now encountering the problem of elevated blood pressure, and arterioselerosis in general. I recently lost one of my pilots from acute coronary occulsion. Ninety days before death, his electrocardiogram was normal. I don't think that unusual; I would say it is the rule rather than the exception.

I had an unusual experience with one of my female pilots. She was approximately eight months pregnant, and called me one day to see if she could fly to Texas to see her folks. She was to be gone about a week but stayed three. When she finally arrived she had to be met at the airport, rushed to the hospital, and was delivered of a 9 lb. boy. I wonder if the child will be a "hot pilot?"

I consider my aviation medical practice one of the potential reserves of aviation in our country. I'm positive there are many bush flight surgeons in our country doing a job of national defense quietly and effectively who never give it much thought. However, we have the added advantage of knowing and associating closely with our pilots and their families and know their fears, frustrations, and moments of happiness. I do not find this type of aviation medicine much different from the aviation medicine I practiced during World War II. The greatest difference seems to be that we all have to pay our own bills, and many times we have to improvise a little to keep things going, but we fly and have fun. In this accomplishment I believe we are doing our country a great service.

323 Unity Bldg.

Why Respiratory Function Tests?

David W. Cugell, M.D., Associate in Medicine, Northwestern University

Ronald E. Fox, M.D., Resident in Medicine

George A. Saxton, Jr., M.D., Director of the Respiratory Center

DOCTOR SAMTER: Today's seminar is a necessary sequel to our recent discussion at Medical Grand Rounds which questioned whether pulmonary function tests are superior to clinical evaluation of the patient with respiratory symptoms and, if so, whether they should become a routine part in the diagnostic work-up of these patients. Doctor Ronald Fox will open today's debate by outlining the general area of respiratory function tests as well as some of the specific problems which are the cause of our uncertainties.

DOCTOR FOX: All of us, I believe, have at one time or another, found it difficult to understand and to manage the patient with impaired respiratory function. While we welcome physiological approaches to diagnosis, we have come to realize that correlation between the patients' symptoms and results of respiratory function tests is occasionally rather poor. To compound the problem we often see striking clinical improvement in the chronic respiratory cripple under therapy without any parallel, measurable change in our objective tests.

The discrepancy is caused, of course, by the multiple etiology of respiratory diseases. Let us consider the symptom of dyspnea. Dyspnea by definition means "difficulty in breathing." In different clinical states, however, like bronchial asthma, pulmonary emphysema, pulmonary embolism or congestive failure, the clinical symptomatology of dyspnea differs. Actually, the mechanism of dyspnea is difficult to establish and is fraught with unknowns. Dyspnea is produced when unknown stimuli act on unknown receptors in the lung which stimulate unknown afferent pathways to act upon an unknown center in the brain.

Thus, no single test can evaluate respiratory function as an entity. We have tests that measure ventilation (vital capacity, timed vital capacity, maximum breathing capacity), distribution of gases within the lung ("nitrogen washout"), diffusion of gases across the alveolar-capillary membrane (alveolar O_2 and CO_2 tensions), and circulation i.e., the differential blood flow to the alveoli. "Breathing" is work performed against compliance of the lung, non-elastic tissue resistance, and resistance to the flow of air within the bronchi. Each constitutes a variable and all our tests still cannot answer the fundamental question: "What causes dyspnea?" Yet, we have information on several of the partial functions of respiration which can serve as a base line for further study.

DOCTOR SAMTER: Thank you, Doctor Fox, for presenting a framework for our discussion. You have remained carefully non-committal about the practical value of these tests: this leaves the burden of proof to Doctors Cugell and Saxton.

DOCTOR SAXTON: Since I am essentially involved in theoretical problems of respiratory function, I would like to ask Doctor Cugell to show us how these tests apply to the every day problems of clinical practice.

DOCTOR CUGELL: In discussing the clinical application of pulmonary function tests, I will limit myself to the most elementary tests which

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TABLE 1

	Ave. in 30 Normal	Ave. in 30 tr 3&4 Mitral Stenosis	Ave. in 30 Emphysema	Case 1	Case 2
% Total VC expired in 1 sec.	90%	90%	40%	40%	35%
Pulm. Mix. Ind.	1.5%	1.5%	6.3%	7.0%	3.5%

we employ, ventilatory tests. Of prime importance is the fact that 90% of patients with chronic pulmonary disease show abnormal ventilatory function. Before I present a few representative cases, I would like to review some of the terms which we use in these tests.

Maximum Breathing Capacity (MBC) is the maximal voluntary ventilatory volume of air exchanged. The expired air is collected or otherwise measured for a 15, 20, or 30 second interval and the MBC is expressed as liters per minute.

Vital Capacity is the maximum volume of air expired after maximum inspiration.

Timed Vital Capacity is the volume of air expired in one, two, or three seconds after maximum inspiration, expressed as a percent of the total vital capacity.

Total lung volume is the volume of air within the lungs at maximum inspiration.

Residual volume is the volume of air remaining in the lungs after maximum expiration. It is equal to total lung volume minus vital capacity.

Pulmonary mixing index is the percentage of nitrogen which remains in alveolar air after seven minutes of breathing 100% oxygen.

Our first case is a 23 year old office worker who complained of dyspnea at rest and on effort. There was no obvious cardiac or pulmonary cause for these symptoms and he was referred to our laboratory for study. The ventilatory tests were normal *except* the spirogram which showed a marked increase in frequency of sighing (deep breathing). A pattern of this type is seen in anxiety states, and after further study the patient proved to have neurocirculatory asthenia. Now I agree that astute clinical observation might have reached the same conclusion, but we were able to record this phenomenon graphically and to suggest a cause for the symptoms.

DOCTOR Ford K. HICK, Professor of Medicine: Were blood studies done?

DOCTOR CUGELL: No, but they would probably have showed a slight decrease in CO_2 tension.

The second and third patients were referred to us for mitral commissurotomy to relieve mitral stenosis. Both patients had incapacitating dyspnea. In both patients there were additional symptoms and the dyspnea was somewhat atypical. Respiratory function tests were performed. The results of these tests are shown in comparison with the results of tests on normal patients, on other patients with severe mitral stenosis and on patients with advanced pulmonary emphysema (Table).

It is apparent that our two patients did not show the typical findings of dyspnea due to mitral stenosis, but those of severe pulmonary emphysema.

DOCTOR Peter K. POIRIER, Resident in Medicine: What do you mean by atypical dyspnea?

DOCTOR CUGELL: Actually, I meant to say their dyspnea was somewhat atypical for uncomplicated mitral stenosis. Both patients had cough, sputum, and some expiratory wheezing, particularly in the morning, in addition to their dyspnea.

DOCTOR Robert J. ADOLPH: Do you infer that the diagnosis could not have been made without these tests

DOCTOR CUGELL: Yes. With combined valvular heart disease and obstructive emphysema it is extremely difficult to assess the relative contribution of each disease to the patient's symptoms.

DOCTOR SAMTER: Were the diaphragms depressed on X-ray?

DOCTOR CUGELL: No. In fact, we have found very little correlation between position of the diaphragm and the degree of emphysema.

Our next two patients (4 & 5) were admitted with the diagnosis of hypertensive cardiovascular disease and extensive pulmonary disease. Both patients complained of dyspnea: it was our prob-

lem to determine, if possible, which condition caused how much dyspnea in each. The first patient had silicosis following many years of work in a granite quarry and in a factory where he was exposed to abrasive dust. His ventilatory function tests were essentially normal: we concluded that his dyspnea was the result of the hypertensive heart disease. The second patient had severe pulmonary emphysema. He showed marked reduction in vital capacity, timed vital capacity, and MBC, with increased total lung volume and pulmonary mixing index. These two patients are examples of differential diagnostic problems in which ventilatory tests may prove to be valuable to determine the cause of dyspnea when two conditions co-exist, either of which could be responsible for it.

DOCTOR SAXTON: Do you mean to imply that the silicosis in case No. 4 was not the cause of dyspnea because the ventilatory tests were normal?

DOCTOR CUGELL: Yes, although if dyspnea is severe there will be abnormalities in the pulmonary function tests. On the other hand, there may be marked radiologic abnormalities in uncomplicated silicosis with minimal symptoms and relatively normal pulmonary function. I believe this latter situation was the case in this patient.

The next case (No. 6) is that of a 58 year old man with marked, perhaps extreme, changes in the bony thorax. When he appeared in our cardiac clinic complaining of dyspnea, his physician believed that the shortness of breath was caused by his ventilatory insufficiency. Yet, we demonstrated normal ventilatory function by the MBC and timed vital capacity. His symptoms were relieved with digitalis and diuretics.

DOCTOR HICK: If he was dyspneic when the tests were done, why did the tests fail to reflect this dyspnea?

DOCTOR CUGELL: He showed no ventilatory abnormality. It is a fact that patients with dyspnea of cardiac origin have symptoms out of proportion to the measurable ventilatory defect, whereas patients with dyspnea secondary to pulmonary disease usually have a ventilatory defect comparable to their symptoms.

DOCTOR ADOLPH: How far should we proceed if no ventilatory deficit exists. Approximately one-tenth of the patients apparently show no deficit. Are further tests indicated in his case?

DOCTOR CUGELL: By all means. In fact, our last case (No. 7) illustrates this problem. A 39 year old foundry worker with exposure to abrasive dust for a long period was extremely dyspneic. His chest X-ray, however, showed only a slight increase in peripheral pulmonary markings. His ventilatory function tests were normal - the usual finding in patients who have symptoms secondary to chronic inhalation of irritants. Further studies revealed low arterial oxygen saturation and low pO_2. He exhibited a marked impairment of diffusion. Lung biopsy showed a non-specific granulomatous infiltration, marked interstitial fibrosis, and hyalinization of the alveolar membranes.

The last two cases (No. 6 & 7), therefore, illustrate instances where only studies which extend beyond ventilatory function can accurately determine the cause of the symptoms. I might add that we also see many patients from our cardiac clinic with a presumptive diagnosis of cor pulmonale. If our entire battery of tests is normal we do not consider cor pulmonale an acceptable diagnosis.

DOCTOR SAMTER: In each of the cases you have presented today, the one second vital capacity correlates well with other tests of ventilation, and the patient's symptoms. Is there, then, any indication for performing the other tests?

DOCTOR CUGELL: Opinions differ in this regard, but basically I agree with you. I perform far fewer tests than many in this field.

DOCTOR Herbert NEUHAUS, Clinical Assistant in Medicine: I have found poor correlation between MBC and one second vital capacity in my patients with cavitating tuberculosis.

DOCTOR CUGELL: Yes, this is to be expected since cavities or blebs empty late with forced expiration. Therefore, MBC may be normal while the one second vital capacity is reduced.

DOCTOR SAMTER: In our asthmatic patients we measured experimentally the "flow rate" as an index of ventilatory function. We have, however, returned to the use of timed vital capacity since it is easy to train the patient in its performance, and its results are consequently more reliable. Many patients become too quickly fatigued for reliable MBC determinations.

DOCTOR SAXTON: I am disturbed about the discrepancy in incidence of cor pulmonale on

both sides of the Atlantic Ocean. The English figures show a much higher incidence than ours; they feel that 70% of all emphysema patients die because of cor pulmonale. Doctor Gellman, do you use, perhaps, different criteria for your diagnosis of cor pulmonale?

DOCTOR D. D. GELLMAN, Research Fellow in Medicine: In England the most common cause of death in patients with chronic bronchitis and pulmonary emphysema is a sudden exacerbation of the disease with dyspnea, cyanosis, neck vein distention, hepatic enlargment, peripheral edema, a loud second pulmonic sound, and prominent anterior thrust with systole: this is what we call cor pulmonale, and I presume you would accept these diagnostic criteria here also.

DOCTOR SAXTON: Doctor Cugell, do you believe that pulmonary functions must be abnormal and that the arterial O_2 saturation must be low before the diagnosis of cor pulmonale is justified?

DOCTOR CUGELL: Yes, although arterial oxygen may be normal, I do not believe that right ventricular hypertrophy alone equals cor pulmonale. Pulmonary disease must, by definition, be present.

DOCTOR Mohammed MOSTAFA, Research Assistant in Respiratory Center: Would you define "pulmonary disease?"

DOCTOR CUGELL: Pulmonary emphysema, is, by far, the most common cause of cor pulmonale.

DOCTOR SAXTON: I should like to add a few disjointed remarks which emphasize some of our difficulties. In patients who were seen in our laboratory before and after mitral commissurotomy, we have noted with some surprise that despite remarkable symptomatic improvement, lung distensibility or "compliance" and vital capacity decrease. Yet they feel better. The only measurable improvement is seen in reduction of pulmonary capillary pressure.

Secondly, in an attempt to outline some easy procedures which will aid our house staff in the management of an acute respiratory problem, e.g., in a pulmonary "cripple," we have suggested three tests: (1) the vital capacity which will be abnormal if ventilatory deficiency is present; (2) the CO_2 content of venous blood which can be measured in our chemistry laboratory as easily as CO_2 combining power; if metabolic acid base imbalance is suspected, a blood pH should also be performed; (3) determination of arterial oxygen saturation before and after O_2 administration. A precise measurement requires a Van Slyke apparatus, but we have set up color standards by which a fairly accurate estimate can be made by simple color comparison under red light. We have found that these tests provide a sound, if approximate, physiological basis for guidance of therapy.

DOCTOR ADOLPH: Since your tests are used not only as a diagnostic tool but also as a guide for therapy, one wonders how accurate they are.

DOCTOR CUGELL: These tests, frankly, are of *least* value in the management of the patient. As Doctor Fox said, we repeatedly see marked clinical improvement without change in the results of a ventilatory test.

DOCTOR GELLMAN: About a year ago I attended a meeting in England where Doctor W. B. Briscoe discussed the reasons for performing respiratory function tests. Among other reasons, he gave first the metaphysical one that he was curious to know what was going on in the lungs, second that they helped him to teach clinicians, third that they gave young doctors something to talk about at the English equivalent of your American Board examinations. Assistance in clinical diagnosis came very low on his list.

I think that much of the clinical information given by respiratory function tests can be obtained in a much more simple manner. For instance, asking a patient to blow out a match with his mouth wide open gives us some indication of his maximum midexpiratory flow rate (perhaps the most important single factor in obstructive pulmonary disease). A patient who can blow out three matches in succession does not have significant impairment.

Another useful clinical test in obstructive lung disease is to auscultate the chest during forced expiration. In emphysema, expiration is prolonged, and high pitched sibilant rhonchi appear early: in the normal patient these rhonchi appear, if at all, only at the very end of expiration. We frequently have to decide whether a patient is more affected by abnormalities of ventilation or of diffusion. We can roughly decide this point by exercising the patient. If he becomes more dyspneic than cyanosed, the problem is one of ventilation. If he becomes more cyanosed than

dyspneic, diffusion is at fault. A great deal about obstructive pulmonary disease can also be learned by intelligent fluoroscopy of the chest, another procedure which the clinician can readily carry out himself.

I was very sorry that none of the previous speakers drew attention to the value of studying the shape of the expiratory spirogram. It is easy to record the vital capacity on a fast-moving drum and from this single curve one can determine vital capacity, timed vital capacity and maximum midexpiratory flow rate. In emphysema this single test is therefore one of the most useful available.

DOCTOR CUGELL: In general I quite agree. I did not mention Doctor Briscoe's metaphysical remarks because I wasn't invited here to discuss the philosophy, but rather the practical aspects of respiratory function tests. It might be well to emphasize, however, at the end of this discussion that only the years of trial and error in the assay of pulmonary function have given real meaning to the clinical methods which Doctor Gellman has mentioned.

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Do-it-yourself

These do-it-yourself crusades in the feminine magazines are playing fast and loose with the established crafts of English life. Most of the spring was marked by blistering the paint off doors with a blow-lamp and making out the resultant claims for the fire insurance people, then surging on knee deep into synthetic paint and synthetic paste for synthetic wallpaper. I called at the chemist's shop on my way home. He always has some cheerful scheme for trying out the latest samples on the unsuspecting but that afternoon his face was unusually grave. He leaned across the counter and asked if my wife was feeling better. I said that as far as I could remember the old girl was last seen at lunch time deep in ideas for brightening up the bathroom. A lot must have happened since then. About 2 o'clock our eldest daughter had bought half a pound of Epsom salts; nothing unusual if that is the way your fancy takes you. But at half past three our youngest offspring had come hurtling down the road on her bicycle, burst frantically into the shop, and demanded another four pounds of Epsom salts for her mummy who wanted it so urgently that she had forgotten to send any money. I made good the outstanding debt and warned the chemist not to sell any dynamite to the family without a signed prescription. The journey home was worryingly punctuated with halt signs and possible diagnoses. I ran up the stairs into the house. No tea ready in the lounge, not a sign of life. Then strange noises floated down from the bathroom. I took the stairs two at a time and banged nervously on the door. The next-of-kin, in an indecently healthy voice, pointed out that the door was not locked but she was too busy to open it, and suggested that I use the one outside. That was no time for false modesty, when the full wealth of my clinical skill might be put to good use at last. My jaw dropped. The better half was kneeling on the windowsill, slapping some opaque decoration on the lower panes of glass. "Here," she said brusquely, "come and help stir up some more Epsom salts before it sets." With a sigh of relief I did it myself, as the magazine said. *In England Now. Lancet, Sept.* 1, 1956.

EDITORIALS

Drug induced illnesses

A century ago, many treatments were worse than the disease. Nowadays, many treatments produce disease, especially when sound therapeutic principles are not employed. Every physician should be on guard to detect these drug and surgically induced disorders.

The best known and easiest to recognize are those associated with steroid therapy. Symptoms include hypertension, drowsiness, hyperglycemia, sodium retention, potassium loss, acne, buffalo hump, hirsuitism, and negative nitrogen balance with muscle wasting and osteoporosis. The abrupt withdrawal of steroids may cause headache, nausea, vomiting, restlessness, and muscle and joint pain. The steroids also are capable of bringing about adrenocortical atrophy leading to adrenal exhaustion at the time of some future stress situation. As a result, it may be wise to test adrenocortical function or administer hydrocortisone to anyone who has received steroid therapy within three to six months previous to encountering a severe burn or accident or when surgery is contemplated.

The rising incidence of periarteritis nodosa since 1936 has been blamed on a nonspecific hypersensitivity reaction to the sulfonamides. A similar reaction to serum injections and other drugs also may play a role.

The hydralazine syndrome (rheumatoid arthritis and lupus erythematosus) has occurred in patients treated successfully with hydralazine hydrochloride (Apresoline). This phenomenon usually begins with the rheumatoid arthritis phase (chills, migrating arthralgia, and myalgia). If the drug is continued the patient progresses into the lupus erythematosus stage, with fever, prostration, cutaneous sensitivity to ultraviolet light, lupus type rash, and enlargement of spleen and lymph glands.

The prolonged administration of hexamethonium for hypertension may lead to interstitial pulmonary fibrosis. This syndrome is characterized by a relentless, progressive dyspnea that may bring death from acute fibrosis within 30 days. Symptoms of epilepsy and parkinsonism have been precipitated with Rauwolfia serpentina.

Many drugs have been implicated in toxic psychoses, hepatic coma, and neuritis. Streptomycin, for example, affects the eighth nerve; and stilbamidine gives rise to facial paresis and hypesthesias. Hepatic diseases have been associated with the use of chlorpromazine, arsphenamine, thiouracil, and methyltestosterone. Toxic hepatitis has been known to follow the use of picric acid, dinitrophenol, gold compounds, chloroform, arsenobenzol compounds, and the sulfonamides.

Hemotoxic drug reactions also are common. A depression of all the bone marrow elements may ensue after amphetamine, Atabrin, phenylbutazone, hydralazine, and anti-epileptic drugs such as Tridione, Mesantoin, and Dilantin. The granulocytic elements of the bone marrow are depressed by dinitrophenol, sulfapyridine, thiouracil, Butazolidin, chloramphenicol, and anti-

histaminic agents such as antergan and Pyribenzamine.

The use of high oxygen concentrations is responsible for retrolental fibroplasia. The dumping syndrome is a well known aftermath of gastrectomy. After eating, the patient experiences a sensation of fullness and churning in the epigastrium, generalized weakness, sweating, tachypnea, tachycardia, pallor, and transient hypertension.

A number of gastrointestinal disorders, ranging from anorectal syndrome to Candida albicans infections, have been traced to the broad spectrum antibiotics. Diseases caused by resistant staphylococci are being recognized, including septicemia and endocarditis. Ulceration and perforation along the gastrointestinal tract follow steroid medication.

In the past, these reactions and drug induced illnesses were blamed on impurities, overdosage, or individual sensitivity. Even though we now know about these syndromes, we remain in the dark as to their cause. Various biochemical, enzymatic, and metabolic lesions are suspected. Idiosyncrasy and hypersensitivity reactions are other possibilities.

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A. M. A. clinical session at Seattle

Ten delegates from the Illinois State Medical Society were seated at the meetings of the House of Delegates. Three alternate delegates were also present, and the President, Chairman of the Council, Director of Public Relations and the Secretary were also in attendance throughout the session. The meeting, held November 27-30, had two meetings of the House of Delegates, held on Tuesday and Thursday. Wednesday was given over to meetings of Reference Committees which sessions were well attended.

The total registration for the meeting was approximately 6,500 and nearly 3,000 members were present. This was a much larger member registration than had been anticipated. There were only 26 resolutions introduced during these sessions, and perhaps the one which was discussed at greater length than all others, was pertaining to the changes which had been proposed in the Principles of Medical Ethics. The Preamble and seven of the ten sections seemed to be acceptable in their present form, but the other sections, especially 6 and 7, needed more specific attention. These were relative to:

1. Division of fees;
2. The dispensing of drugs and appliances;
3. The corporate practice of medicine;
4. Greater emphasis concerning the relationship between physicians and patients.

The reference committee recommended that the proposed Principles of Medical Ethics be referred back to the Council on Constitution and By-Laws for further study and consideration of the above stated principles. It was further recommended that this study be completed at least six weeks prior to the June session and that the new version be published in The Journal in order that all interested physicians might have an opportunity to comment thereon.

A resolution was introduced recommending discontinuance of the interim sessions, or clinical meetings. The House adopted a reference committee report which recommended that these interim sessions be continued because of the public relations value to the A. M. A. and the educational value to the physicians and the general public in the various geographical areas involved. It was also urged that maximum attention be given to these potential benefits in selecting a city for the interim session.

Although there were not nearly as many technical exhibitors at the interim meetings as are housed for the regular annual meetings, the exhibitors seemed to be quite busy throughout the session, and seemed well satisfied with the interest shown in their exhibits. There were many scientific exhibits as usual which were likewise very popular and well attended throughout the meeting.

Several state societies presented checks to the American Medical Education Foundation: California, $132,981; New Jersey, $25,000; Utah, $11,870, and Arizona, $3,695. The A. M. A. contributed another $125,000 to this fund, bringing its 1956 total, to $343,000.

The 1957 Annual Meeting will be held in New York in June and the Clinical Session in Philadelphia the last week in November.

The Seattle and State of Washington Committee on Arrangements had done a fine job and had members present on all occasions to aid the out of state members.

Medicine and the "Third Party"

It would be difficult, if not impossible, to set down remarks about this topic without repeating what has been said many times. Too often these remarks have been set down in moments of anger and during stormy sessions when much more heat than light has been shed on the problem at hand. On other occasions, politeness or mutual professional respect on the part of the negotiators, has prevented clear-cut expression on points of disagreement.

With the social trends of the past two decades and the continuous economic spiral upward, it appears that calm, deliberate consideration by all parties concerned is now mandatory. The time has come for the medical profession to admit with all possible candor that physicians must be adequately compensated for the services they perform. The "Third Party" is with us to stay. The survival of the private physician now depends on unity within the profession and firm and honest representation in dealing with the "Third Party".

An agreed objective is necessary before proper negotiation can be started. Therefore, it would appear that the agreed objective should be: "Good medical, surgical and obstetrical care to patients, and this care administered by a physician and/or surgeon of the patient's choice; and this care obtainable at a reasonable cost."

To attain this objective, considerable effort has been made in the past two decades and much impetus has been given in the past decade by insurance companies, pre-pay plans, (Blue Cross, Blue Shield, etc.), and industrial management and labor union plans. With the rapid strides made in medicine in recent years the cost of the desired objective has risen so rapidly that it has become difficult to formulate any plan which can be calculated with the actuarial accuracy that is necessary if such plan is to remain solvent and discharge its responsibility.

Who are the parties to the problem of medical care? First, and always to remain first, is the patient, his ills, the ills of one dear to him, or the ills of one for whom he is responsible. Second, by necessity and by tradition, is the physician and surgeon. The "Third Party," is the plan for profit, plan not for profit, and the management and labor union plan to assist the patient in paying for his illness.

The ideal is for each of the three parties to have mutual respect for the other two. This respect can come only when basic rules of honesty and integrity are practiced by all concerned.

The patient should confine his complaints to his illness and choose a physician in whom he has implicit faith. To do otherwise immediately precludes successful management of any case. Few, if any, physicians would care to make a diagnosis or carry out treatment in any given case without being assured of the full confidence of the patient.

The physician, in return for the faith and trust placed in him, is obligated to see that the patient receives good medical, surgical and obstetrical care at a reasonable cost. The physician should at all times be willing to request aid of his colleagues in any case in which the progress is other than that desired or to be expected in the light of our current knowledge. The physician should also be willing to have any contested fee arbitrated by a group of fellow physicians who have been given the facts in any given case.

What then is the function of the "Third Party" in this important triangle? The "Third Party" is present to assist the patient in paying for his medical care. Insurance companies and pre-pay plans with their actuarial experience tell the patient in his policy what to expect in the way of assistance, which invariably is in direct proportion to the amount of premium paid, and the patient chooses his physician. Unfortunately, the management and labor union plans have not been as considerate of either the patient or the physician. Admittedly it is a herculean task to keep the management and labor union funds solvent. These funds should perhaps revise their thinking and practice more realism and less paternalism in discharging their responsibilities of stewardship. It is not realistic for a physician to charge one fee to a $24 a day industrial worker's labor union fund and then charge a higher fee for the same service to a less fortunate friend or relative of the same patient who earns his living in some other type of work. It is equally unrealistic for the medical profession to accept a plan whereby someone other than the patient chooses his physician and/or surgeon.

Report of Illinois State Medical Society Advisory Committee to the United Mine Workers of America Welfare and Retirement Fund. Adopted by Council of Illinois State Medical Society—Dec. 16, 1956.

Certainly the problems of the "Third Party" will always be with us. Misunderstandings can be expected just as inefficiency and unreasonable fees are inevitable. However, as Lincoln said, "No nation can be half free and half slave." The medical profession likewise cannot be "half free and half slave."

The attached agreement formulated after mature consideration of all parties concerned is presented to you. Your Committee feels the rights of the patient, the physician and the "Third Party" are safeguarded — any other agreement would lead to medical care of an inferior type.

The contract for services and the compensation for services must always remain a matter between the patient and the physician if a satisfactory patient-physician relationship is to be maintained. Any "Third Party" entering into this medical care picture must of necessity do so with a sound fiscal policy and a cooperative attitude.

The undersigned constitute a duly appointed Advisory Committee to the United Mine Workers of American Welfare and Retirement Fund. This Committee attempted to cooperate with the fund in formulating policies and procedures for medical care of beneficiaries.

The Illinois State Medical Society agrees that the objective of the Fund should be to provide good medical, surgical and obstetrical care to its beneficiaries at reasonable cost. This medical care should be furnished by the physician or surgeon of the patient's choice.

Repeated meetings and consultations with representatives of the United Mine Workers of America Welfare and Retirement Fund have failed to produce an agreement which embodies the aforementioned principles, deemed essential to any agreement entered into by the Illinois State Medical Society.

It is obvious that publication of a list of so-called participating physicians by the Fund effectively circumvents the basic principle of free choice of physician by the beneficiaries of the Fund. It is equally apparent that the Fund exerts an arbitrary power to remove physicians and hospitals from their so-called participating list despite the fact that these physicians and/or hospitals are recognized by accreditation bodies constituted within the medical profession. The Fund also refuses to accept recognition of hospitals and/or physicians on the basis of proved ability, as determined by local accrediting agencies.

It is therefore recommended to the Council that the Illinois State Medical Society reluctantly, yet firmly, condemns the attitude assumed by the United Mine Workers of America Welfare and Retirement Fund as stated by their medical representatives.

It is further recommended that the Illinois State Medical Society inform each member of its decision in the matter.

It is finally recommended that the Illinois State Medical Society inform each of its members that it does not look with favor upon any member physician who includes the United Mine Workers of America Welfare and Retirement Fund in negotiations for medical, surgical and obstetrical care for any beneficiary of the Fund.

Burtis E. Montgomery, M.D., Chairman; James A. Weatherly, M.D., Vice Chairman; Willard W. Fullerton, M.D.; David Bennett, M.D.; J. A. Mathis, M.D.; Charles Ahlm, M.D.; Kenneth H. Schnepp, M.D.; Arthur R. Brandenberger, M.D.; Edwin C. Bartelsmeyer, M.D.; Willis I. Lewis, M.D.

MEDICAL ECONOMICS

New Workmen's Compensation Law and Rehabilitation Act Prepared by Illinois State Medical Society

FREDERICK W. SLOBE, M.D., CHICAGO

IN December, 1955, the House of Delegates of the American Medical Association adopted a report on medical relations in workmen's compensation to guide the medical profession in the evaluation and implementation of progressive workmen's compensation programs. The House of Delegates of the Illinois State Medical Society directed its Committee on Industrial Health to develop a program, including necessary legislation, to implement the recommendations contained in the A.M.A. report.

The Committee first considered drawing up certain amendments to existing laws. Finally, however, because medical relations in workmen's compensation are so intimately connected with all aspects of a workmen's compensation program, entirely new legislation seemed necessary. A bill designed to rehabilitate occupationally injured employees to health and vocational opportunity as able-bodied and self-supporting citizens will be submitted to the General Assembly in January. Pertinent features of the bill are discussed in the following paragraphs.

The significance of the title, "The Workmen's Compensation and Rehabilitation Act," is apparent in that attention is immediately directed toward the importance of medical rehabilitation.

Old Workmen's Compensation and Occupational Disease Laws Combined in One Law

This has several advantages and is made possible by certain definitions used. There is precedent for these definitions in other state laws and in supreme court interpretations. For example, pertinent definitions are as follows: "*Injury* means the mental or physical harm to an employee caused by accident or disease arising out of and in the course of employment." "*Disease* means a disease arising out of exposure to harmful conditions of the employment which conditions are present in a peculiar or increased degree by comparison with employment generally." "*Accident* means only an unexpected event which occurs without the affirmative act or design of the employee." Thus, no specific diseases are mentioned and benefits for silicosis or other diseases are neither limited nor treated differently from disability formerly ascribed to traumatic injury only. Seventeen states now have compulsory inclusion of all occupational diseases.

Workmen's Compensation and Rehabilitation Commission

The bill sets this up as an independent and separate State agency. All employees, however, will be under the new Department of Personnel with the exception of the Commissioners, the members of the Board of Appeals and the Deputy Commissioners. The Commission will consist of three members having staggered terms of 6 years, appointed by the Governor with the

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Chairman, Committee on Industrial Health

Senate's advice and consent and consisting of one attorney, one physician, and one person especially experienced in public or business administration. All three members cannot be of the same political party. The Commissioners do not hear cases but have complete charge of administering the Act. All hearings are conducted before the deputy commissioners.

State Council

This will consist of 10 members appointed by the Commission, with two members representing each of the following groups: employers, employees, lawyers, physicians, and insurance carriers. These have two year terms and have quarterly meetings to study problems pertaining to the administration of the Act, including rehabilitation.

Medical Advisory Committee

This committee will be appointed by the Commission. In the appointments, consideration is given to recommendations made by the Illinois State Medical Society. The committee consists of 5 members, all having two year terms, the physician member of the Commission acting as chairman and ex officio member. Important functions of this committee will be to advise the Commission on medical policy and practices, including rehabilitation: to prepare registers of physicians willing and qualified to serve injured employees; to prepare regulations jointly with the Commission; to mediate complaints by or against physicians concerning reports, testimony and payments; to make recommendations as to removal of names from the register; and to supervise fees and charges of physicians and hospitals.

Workmen's Compensation and Rehabilitation Board of Appeals

This will be independent of the Commission except for budget keeping and administrative expense purposes only. It consists of three members appointed by the Governor, all being full time, all attorneys and having 6 year terms. One is assumed to be representative of the employers, one of the employees and one representing neither. This Board hears appeals on questions of both law and fact from any decision of the Commission on a claim for compensation.

Medical Rehabilitation - Choice of Physician

The employee will have the right to accept the services of the physician designated by the employer or to select a physician from a register of physicians recommended by the Medical Advisory Committee and approved by the Commission for the community in which services are required. Thus the choice, though broadened, remains limited, the number on the register varying with the area and local conditions. After this initial choice, the employee may select another physician once but, thereafter, any change can be made only on the Commission's approval. There are regulations about sending in reports promptly and the submission to examination by another physician at the request of the employer or Commission. The Commission, after consultation with the Medical Advisory Committee, has authority to make rules and regulations regarding fees for professional and hospital services.

Obviously, since the cost of medical care is borne by the employer, and since the new law gives the patient the right of choice of physician, it follows that certain safeguards are necessary both as regards charges and quality of care. As concerns fees, there is really no change in the law since the present compensation law gives the Commission "the power to determine the reasonableness and fix the amount of any fee . . . charged by any person, including attorneys, physicians, surgeons and hospital, for any service performed in connection with this Act." And it is believed that the new law furnishes ample safeguards through the Medical Advisory Committee and the fact that one of the members of the Commission must be a physician. It is believed that by efficient administration, likewise, the quality of care can be supervised so that both the employee and the employer are protected.

Some physicians whose major interests and affiliations are in occupational medicine may view a system of limited "free" choice of physician with misgivings. These should bear in mind that the physician furnishing adequate and proper service is usually rewarded by gaining the confidence of the employees and thereby accepted. Furthermore, he has the satisfaction of knowing that he is acceptable to the employee and not forced upon him. Also, that the new law contains safeguards against abuses and penalties for coercion, misrepresentation, and other circumventions of the spirit and intent of workmen's compensation. The Wisconsin system is similar to that proposed here and it has proved mutually satisfactory to all concerned.

Complete medical care is provided with neither time nor money limitation; training in the use of prostheses is included. Also, there is appropriate provision made for occupational diseases which may not be manifested until a considerable time has elapsed.

There is variation among states regarding choice of physician and the existence of fixed fee schedules. A study of insurance statistics fails to indicate any uniform relationship between either choice of physician, fixed fee schedules or both, and workmen's compensation costs.

Vocational Training

This is given considerable prominence because the avowed purpose of the new law is rehabilitation and restoration of occupationally injured employees to health and vocational opportunity as self-supporting citizens. Active medical rehabilitation is assumed to be part of total treatment. In addition, the employee is entitled to such vocational training as may be necessary to restore him to his former job or suitable employment. The State Division of Vocational Rehabilitation may be utilized for this purpose. The employer, however, is not liable for any expense for such services unless he elects to provide them under some private auspices approved by the Commission. It is mandatory to refer patients for vocational rehabilitation training if there is likely to be partial or total incapacity for a remunerative occupation. Final decision is withheld until maximum medical and vocational rehabilitation have been attained.

The need for a closer integration between workmen's compensation administration and rehabilitation is urgent. Treatment should be pointed toward rehabilitation from the very beginning. But most jurisdictions have experienced difficulty putting this into practice. There is ample proof that a well directed rehabilitation program, in addition to its humanitarian aspects, lowers medical costs in the aggregate as well as costs applicable to permanent impairment.

Second Injury Fund

As in the present law, the employer makes a payment into a special fund when an employee loses one eye, foot, leg, arm or hand. Then, if in a subsequent injury another member is lost, the Fund takes over the excess loss occasioned by permanent disability beyond the loss of the second member alone. The new bill does not extend the scope of the Fund to instance of aggravation of pre-existing conditions. Although entirely sympathetic with these problems, it is believed that sufficient factual data to serve as a basis for a blanket inclusion of pre-existing conditions in the Fund are not available. Current developments indicate that a practical, fair resolution of this problem may be expected in the foreseeable future.

Indemnity Benefits

Compensation for permanent disability is based on medically determinable residual improvement after maximum rehabilitation without regard to current earnings. Such a basis appears to be medically and scientifically sound. Payments are based on weekly installments of a certain percentage of average weekly earnings, the exact percentage being left blank as this was a matter which was not considered to be within the scope of the Medical Society. Using the percentage of average earnings as a basis appears logical. This percentage is not varied, depending upon marital state or the number of children any more than that the employee's wages vary because of this. Permanent total disability is paid for life. Permanent partial disability for conditions other than scheduled amounts related to members, such as an arm, finger or eye are also payable for life but not to exceed a certain number of weeks, the exact number being left for other groups to determine. The determination of this, again, is based on medically determinable residual impairment after maximum rehabilitation, without regard to post-injury earnings. The schedule for loss of members such as the arm, leg, finger and eye is based on a certain percentage of average weekly earnings paid. The number of weeks paid for an arm or leg again is not entered, again being beyond the scope of the Committee's function. There are provisions in some jurisdictions for payment based on a percentage of what the loss of an arm, for example, would be to a total permanent disability of the whole person. Such a basis has much to recommend it but it is believed that sufficient medical data are not yet available to indicate its adoption at this time.

There is no schedule for hernias or disfigurement, it being believed that these conditions will be judged on their own merits within the scope of the law.

Compromise Settlements

These are provided only when the dispute is limited to the question of liability and the parties' rights. They are not available when the only question is the extent of disability.

Settlement Agreements

These must include a stipulation recording the facts and findings, the medical costs, the amount of indemnity paid and whether the employee has returned to work. If a compromise, the employee must sign a statement indicating that he understands it is a final, permanent settlement, and that he is aware that he has the right to take his claim to the Commission.

Lump Sum Payments

Limitations are provided in allowing these, including the requirement of a specified time interval before they are submitted for approval.

Procedure for Hearings

All original hearings are before the deputy commissioners. Their decisions are conclusive unless a petition for review is filed before the Board of Appeals.

There is provision for taking depositions of witnesses in lieu of attendance at hearings. This is something which should be of considerable interest to physicians. There is provision for judicial review of decisions on questions of law only.

Penalties

There are penalties for solicitation of employment by anyone for himself or another regarding any claim or case; for the coercion of employer or employee in the exercise of their rights and responsibilities; for contempt; for willfully making any false or misleading statement or representation for the purpose of obtaining or defeating any benefit, fee or allowance under the Act; for receiving fees on account of services rendered as representative of the employee, unless approved by the Commission. It is believed these penalties should go a long way in eliminating certain abuses, particularly the section dealing with misrepresentation and solicitation.

The Bill's Future

The future of this bill or any portion of it can only be surmised at this time. It is the Committee's sincere belief that this bill, if passed and efficiently administered, offers substantial improvement over the present system. Obviously, it will require a much greater budget than is presently available. Various groups have introduced bills in the past representing industry, labor and other interests, but it has been the Committee's aim to try to draw up a bill with the specific objectives of obtaining maximum medical rehabilitation of the employee and efficient administration of the act. In endeavoring to do this, it is cognizant of the complementary relationship existing between good medical care and good administration of the Act because one cannot be obtained without the other. It is believed that the increased State budgetary requirement is something for which there has been a crying need for many years. It is believed that the cost to the employer will not be increased; on the contrary, good medical care and sound administration of the Act should reduce the eventual costs.

The foregoing is not a criticism of the present administration of the Workmen's Compensation Act because it is realized that the agency is understaffed and that it is impossible to carry out many of the objectives of workmen's compensation with an insufficient number of personnel, an inadequate salary level, inadequate budget, insufficient space and a law which leaves much to be desired.

With an industrial society which is becoming more complex and increasing in numbers and scope, the medical profession is increasingly cognizant of its responsibility in the medical care of injured employees. It is hoped that all interested groups as well as individual physicians will do their utmost in facilitating passage of this important legislation.

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THE P. R. PAGE

Edward A. Uzemack, Director of Public Relations

ONE of the most vexing problems in the internal public relations of the Illinois State Medical Society lies within the category of mass communications . . . How can we most effectively get essential information into the hands of our more than 10,000 physician members?

Direct mail, publicity in the state Journal and county bulletins, speaking engagements and communication through local societies have been tried with varying degrees of success. None has ever reached the point of ideal efficiency.

In talking to physicians in various parts of the state during the past several months, I have found vast gaps of knowledge on matters pertaining to organizational affairs. I have been confronted with complaints that the state society fails to keep its membership properly informed.

Some of this criticism may well be justified, and the state society will continue its attempts to improve communications with its membership. However, the complaints begin to lose weight when there is evidence that many physicians take little interest in the affairs of their county societies, from which come the directives that guide the activities of the House of Delegates, the State Council and their various committees.

After all it is at the county meetings where organizational information is most readily available, since the secretary of the Illinois State Medical Society corresponds regularly with the secretaries and other officers of the respective local societies. The periodic "Secretary's Letter", emanating from Monmouth, Illinois is a valuable source of information on ISMS activities.

Some physicians complain that they know little of what goes on at the annual meetings of the House of Delegates (because of their inability to attend), yet they admit that they have not taken the time to read the report of the proceedings of the House of Delegates, which is always published by the Journal. This year the proceedings took the form of a supplement for the special convenience of busy medical practitioners.

The Journal itself, which goes each month to every member of the society, contains many informative articles on the socio-economic aspects of medicine and other items of general interest to the profession. But it is apparent that many doctors fail to read these articles.

The society's associate counsel, Walter Oblinger, publishes an excellent report on medical legislative matters at frequent intervals. It is called the "Information from Springfield for Medical Societies" and is available free of charge to any member of the society who asks to be placed on the mailing list.

A request for the Springfield newsletter gives us reasonable assurance that it will be read. It has been demonstrated that routine mailing of

this informative publication to all members of the society would be a waste of paper and postage. Since the Illinois legislature meets this year, and your society will support and sponsor a number of pieces of legislation important to medicine, it would be well worth a physician's time to have himself placed on the mailing list for "Information from Springfield for Medical Societies." This can be done by writing to the Director of Public Relations, Illinois State Medical Society, 185 N. Wabash Ave., Chicago 1, Illinois.

These are only a few of the ways in which the society seeks to inform its membership. But even these methods fail if the physician members neglect to take advantage of the services. No individual can be compelled to absorb information; he can benefit from these efforts only if he wants to be informed.

Since it is obvious that our system of internal communications is far from perfect, we welcome suggestions from the membership on how it can be improved. Perhaps there is a voice in the field with just the right answer to this perplexing problem.

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Nonallergic rhinitis

The recent use of rauwolfia serpentina and its alkaloids in the treatment of hypertension has added a new and frequent cause to the etiologic factors responsible for the nonallergic type of vasomotor rhinitis. The use of antihistaminics concomitantly with these antipressor drugs is recommended prophylactically. *Samuel L. Fox, M.D. Vasomotor Rhinitis in Hypertension. Maryland M.J. March* 1956.

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A needless adjective

Sir, — On opening last week's issue I was horrified to see on p. 421 in the title of an original article, the term "skin rash." While I am accustomed to mothers who bring children to my outpatient department from the areas behind Victoria Station remarking "'e's got a skin rash, doctor," my students never use this phrase in my presence more than once. "Skin eruption" and "rash" may be used according to taste, "skin rash" surely never.

John Franklin
London, W.1

Communications. Lancet, Sept. 8, 1956.

Oral hypoglycemic agents

Several thousand diabetic patients up to now have been treated with the oral hypoglycemia sulfonamide compounds in Europe and the United States. They are administered as 0.5 gm. tablets, two to four per day, in one or two doses, after a priming period of a day or two with larger doses (6 tablets). They are effective in 50 to 80 per cent of cases, depending on the selection of cases and the index of therapeutic success accepted. Older patients with disease and insulin therapy of shorter duration are said to react most favorably. Patients with severe disease or juvenile diabetic patients show the least effect, although the tablets could be used to reduce their insulin needs. The exceptions are so numerous, however, that any diabetic patient could be offered the therapy - in the most severe cases, however, with hospitalization. The evidence for permanent benefit to the diabetes, human or experimental, seems doubtful at present. Toxicity has been minimal, with mild skin rashes in 1 per cent and no evidence of serious liver, kidney, or hemopoietic effect. There has been no development of resistance to the drug to date. *Samuel B. Beaser, M.D. Diabetes Mellitus. New England J. Med. Aug.* 21, 1956.

CORRESPONDENCE

Clinics for crippled children listed for February

Twenty five clinics for Illinois' physically handicapped children have been scheduled for February by the University of Illinois Division of Services for Crippled Children. The Division will count 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social, and nursing service. There will be 3 special clinics for children with cardiac conditions, 2 for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in co-operation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The February clinics are:

February 5 - Vandalia, American Legion Home

February 6 - Alton (Rheumatic Fever), Memorial Hospital

February 6 - Hinsdale, Hinsdale Sanitarium

February 7 - Macomb, St. Francis Hospital

February 7 - Litchfield, Madison Park School

February 8 - Chicago Heights [Cardiac], St. James Hospital

February 12 - East St. Louis, Christian Welfare Hospital

February 12 - Peoria, Children's Hospital (St. Francis)

February 13 - Aurora, Copley Memorial Hospital

February 14 - Springfield, St. John's Hospital

February 14 - Tuscola, Community Building

February 15 - Evanston, St. Francis Hospital

February 20 - Chicago Heights [General], St. James Hospital

February 20 - Elmhurst [Cardiac], Memorial Hospital of Du Page Co.

February 20 - Metropolis, Presbyterian Parish House

February 20 - Carrollton, Carrollton Grade School

February 21 - Anna, County Hospital District

February 21 - Rockford, St. Anthony's Hospital

February 22 - Chicago Heights [Cardiac], St. James Hospital

February 26 - Belleville, St. Elizabeth's Hospital

February 26 - Effingham (Rheumatic Fever), St. Anthony Hospital

February 26 - Peoria, Children's Hospital St. Francis

February 27 - Elgin, Sherman Hospital

February 27 - Springfield (Cerebral Palsy), Memorial Hospital

February 28 - Bloomington a.m. (General), St. Joseph's Hospital; p.m. (Cerebral Palsy)

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Letter from woman's auxiliary

Dear Doctor:

Do you wonder why this sudden deluge of appeals to you from the Woman's Auxiliary for your wife's membership? It's very simple, really: — you are the doctor, and you alone can cure the ills of the unaffiliated and uninitiated wife!

Woman's Auxiliary is the only field in which I would presume to diagnose or prescribe, but in this field I believe I am on firm ground. The pernicious condition to which I have referred might be called "auto-indifference." Your wife's symptoms are clear-cut: she may have only some of these symptoms or all of them — either she lacks knowledge of the purposes and work of the Woman's Auxiliary, or she lacks interest, or she's too busy, or she just never has given it a thought — but the therapy is the same regardless of the syndrome, and you have the power to administer it. You merely insist that she become a member of the auxiliary, and you initiate the project by mailing her membership fee to its proper destination. That's the office treatment, doctor; then you can relax, and the Woman's Auxiliary will nurse your wife into a healthy, happy, well-informed member. The whole procedure is painless and so rewarding.

I am addressing myself to the doctor husband of every wife in Illinois who is eligible but not already enrolled as a member. But, specifically, I am directing this message to you who live in communities where there are no existing county auxiliaries. Your wife will be the so-called Member-at-Large. She has the happy privilege of being an Illinois Woman's Auxiliary member, for which you pay $3 per year. There are more than 800 men like you in Illinois, and only approximately 90 of you have wives who are members-at-large.

A member-at-large has all the advantages of auxiliary membership, with only as many obligations as she cares to assume. She is entitled to attend all meetings and functions of both the state and county auxiliaries anywhere in the state, and she is assured of a welcome. She is kept informed on all activities of the auxiliary — mental health, medical education, medical legislation, Today's Health, recruitment of nurses and medical technicians, civil defense, public relations, safety. In the interest of brevity and to avoid the "ennui" born of repetition, I shall not elucidate the many facets of this organization. Instead, I shall ask you to place a sort of "blind faith" in us, and send me $3 for your wife. We shall take over from there, and you won't regret your gamble. We make no demands on your wife; there are many among us who can and will work, and we need only to be augmented by the nominal support of volume membership. We are confident that your wife, once enrolled, will become an inspired member — that she will feel herself a vital component of a dynamic force in the world of "medicine."

To date our voice has been a squeak in the prairie. Help us to evoke a resonant and harmonious choral in the nation!

Respectfully yours,
Mrs. Harry A. Mittleman
Chairman, Members-at-Large

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American Trudeau Society meeting

The 52nd Annual Meeting of the American Trudeau Society, medical section of the National Tuberculosis Association, will be held in Kansas City, Missouri, May 6 to 9, 1957, in conjunction with the Annual Meeting of the National Tuberculosis Association.

In addition to scientific sessions at which papers will be presented on current research, plans are being made for seven special lectures and four panel discussions. Topics for the latter will be tuberculin testing, fungous diseases, tuberculosis case finding, and the surgical approach to the bad chronic case of tuberculosis.

The lectures will be on cor pulmonale, chest injuries, hazards of radiation, tuberculosis in animals, histologic studies in smoking, mucovisidosis, and diseases of the diaphragm.

Papers for the scientific sessions will be selected from abstracts submitted to the Medical Sessions Program Committee prior to January 8, 1957. Six copies of the abstracts should be sent to Dr. Edward J. Welch, chairman, 1101 Beacon Street, Brookline 46, Massachusetts.

International academy of proctology

Plan now to attend the 9th Annual Convention of the International Academy of Proctology at The Plaza, New York, New York, April 29, 30, May 1, 2, 1957. The International, National, and Local Program Committees are planning an unusual seminar on practical technics for office and hospital. There will be special emphasis on anal and rectal panel presentations, and on newer treatment methods, as requested by those who attended the Chicago meeting in 1956.

Eminent speakers from all parts of the country and abroad will present interesting papers and motion picture demonstrations of their personal technics. Mexico is expected to be very well represented at this meeting.

The Delegates and Trustees, and their wives, are cordially invited to cocktails and dinner on Sunday evening, April 28, 1957, the evening before the official opening of the scientific activities of the Convention. Both members and nonmembers of the Academy, and their wives, should plan to attend the Thursday night, May 2nd banquet. The Banquet Committee promises the best cocktails and hors d'oeuvres in New York (prepared by the masters of the Plaza cuisine), and the finest dance music and entertainment for your pleasure.

The Women's Auxiliary has planned a very unusual program for the wives of the members and their guests.

Please remember that all physicians and their wives are cordially invited to attend the Annual Conventions of the International Academy of Proctology, whether or not they are affiliated with the Academy. There is no fee for attendance at these teaching sessions of the Academy.

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National medical foundation for eye care

Announcement was made in November of the establishment of the National Medical Foundation for Eye Care, a non-profit scientific and educational institution, incorporated in New Jersey. The Foundation has been organized by ophthalmologists of the country to provide American ophthalmology with an agency to present to the public generally and to fellow physicians pertinent information on the care and treatment of the eyes.

Dr. Ralph O. Rychener of Memphis is president of the Foundation; Dr. Edwin Forbes Tait of Norristown, Pa., vice-president, and Dr. Charles E. Jaeckle of East Orange, N.J., secretary-treasurer.

Members of the Board of Trustees, in addition to the above named, are Dr. Alson E. Braley of Iowa City, Iowa; Dr. Frederick C. Cordes of San Francisco; Dr. Paul Chandler of Boston; Dr. J. Spencer Dryden of Washington, D.C.; Dr. Harold F. Falls of Ann Arbor, Mich.; Dr. Everett L. Goer of Houston; Dr. Erling W. Hansen of Minneapolis; Dr. A. D. Ruedemann of Detroit; Dr. Barnet R. Sakler of Cincinnati, and Dr. Derrick Vail of Chicago.

In a special statement announcing the Foundation's establishment, Dr. Rychener declared: "American ophthalmologists have long recognized an urgent need for an organization whose principal function will be to interpret the basic professional and scientific standards of good eye care for the American people, both to our fellow physicians and to the people whom we serve.

"The National Medical Foundation for Eye Care will seek to serve the public interest by helping the people to understand the educational qualifications and the professional functions of physicians specializing in ophthalmology, and the functions of related technical and ancillary personnel who assist them. The Foundation will also endeavor to keep colleagues in the medical profession informed concerning the problems confronting ophthalmology in its efforts to fulfill its mission as a member of the team of recognized medical specialties serving the American people."

Dr. Rychener revealed that the Foundation is now enrolling its charter membership, and he invited all ophthalmologists and other physicians interested in eye care to become charter members of the Foundation.

Applications are available through Dr. Charles E. Jaeckle, Secretary-treasurer, at 136 Evergreen Place, East Orange, New Jersey. The Foundation planned to establish an administrative office in New York City in January and also make available an Affiliate Membership for persons other than doctors of medicine who are interested in aiding the purposes of the Foundation.

The object and purpose of the Foundation is to advance the public welfare by:

1. Gathering, receiving, assembling and studying information relative to eye care.

2. Fostering and/or engaging in investigations and research in all aspects of eye care.

3. Sponsoring studies of educational, socio-economic and scientific factors affecting eye care.

4. Issuing reports and otherwise disseminating information relative to eye care to the general public and to members of the medical profession and ancillary workers.

5. Promoting the conservation of vision and the prevention of blindness through the wider dissemination of knowledge of the eye, its defects, dysfunctions and other diseases and their relation to general health.

6. Promoting a more effective utilization of the scientific knowledge of ophthalmology and the other related branches of medicine.

7. Generally performing any act, related to the foregoing, designed to present to the public generally and the medical profession, all pertinent information on the care and treatment of the eyes.

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Course on fractures

An intensive course on fractures and other trauma will be offered to all interested members of the medical profession by the Chicago Regional Committee on Trauma of the American College of Surgeons. The course will be held for three and one-half days, from April 10 to 13, 1957, at the John B. Murphy Auditorium, 50 East Erie Street, Chicago.

Lectures and demonstrations will be conducted by distinguished surgeon-teachers of the Chicago area, all recognized as authorities in their fields. Clinical cases will be presented, and discussion and questions from the floor are invited.

Subjects to be covered include bony trauma, soft tissue trauma, vascular injuries, bone grafting, traction technic, industrial casualties, farm injuries, auto crash injuries, burns, amputations and head injuries.

The course is being given under the direction of Dr. Sam Banks.

Further information about the meeting will appear shortly.

Army doctor trained at navy diving school

Major Gerald Champlin of the Army Medical Corps completed a ten-week course at the Navy Deep Diving School in Washington, D. C. on November 23, according to the Office of the Army Surgeon General.

Major Champlin, the first Army doctor to go through the Navy course, was sent by the Army Surgeon General as the first move in a program to provide Army divers with doctors trained to cope with the special medical problems of deep-sea diving.

Little known fact is that the Army has about 200 qualified divers engaged in construction, repair, demolition and underwater work throughout the world.

Major Champlin, post surgeon at Ft. Eustis, Va., has now experienced first-hand the physiological and psychological reactions to deep-sea diving and has learned techniques of treating "the bends," and handling other problems related to compression, decompression and recompression.

The Army operates its own diving school at Ft. Eustis, and Major Champlin will now return to the post to take over medical surveillance of diving operations there. He will also serve as consultant to the Army Surgeon General in matters of diving medicine, and is expected to develop recommendations for further medical training in this specialized field.

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Preventive medicine residency program established by army medical service

The Army's first formal residency training program in preventive medicine will begin July 1, 1957, according to an announcement by the Army Surgeon General's Office, Washington, D. C.

Establishment of this new program is in keeping with the Army's leadership in the field of preventive medicine.

Regular Army Medical Corps officers or qualified civilian physicians who accept commissions in the Regular Army are eligible to participate in this program, according to the announcement. Interested civilian physicians may apply to The Surgeon General, Department of the Army, Washington 25, D. C., Attn: Chief,

Personnel Division. Military personnel should apply through appropriate channels.

This residency is a three-year program providing both civilian and military training.

The first year of training will be an eleven-month course in military preventive medicine at Walter Reed Army Institute of Research in Washington, D. C., or an equivalent graduate course in preventive medicine or public health at a civilian university.

The second year of the program will be spent in an approved civilian residency training program in a city, county, district or state health department.

The third year of the program will consist of formal military residency training at a large Army post with a small portion of the time at a nearby Army headquarters under the supervision of the preventive medicine officers. This third year of the program is now being developed and appropriate application is being made for the approval of this program by the Council on Medical Education and Hospitals of the American Medical Association.

This training is followed by three years of practice in the specialty to establish eligibility for Board examination. The military phase of residency training may be omitted for certain individuals with previous military experience.

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Psychiatry in occupational health

The Institute of Industrial Health, College of Medicine, University of Cincinnati, announces that a course of instruction on Psychiatry in Occupational Health will be given during the week of March 11-15, 1957. It will be presented by the Department of Preventive Medicine and Industrial Health in collaboration with the Department of Psychiatry, University of Cincinnati, with the cooperation of the Committee on Industrial Psychiatry of the American Psychiatric Association. The objective of this course is to give physicians more understanding of the prevention of emotional and psychosomatic disorders in the occupational setting.

The program, each morning and afternoon, and on some evenings, will include lectures, clinical demonstrations and panel discussions by participants from various parts of the United States and Canada. These will cover basic attitudes and techniques useful in occupational medicine from psychiatry and allied fields, the principles of cooperation in preventive psychiatry by the physician in industry, and the discussion of various practical problems such as absenteeism, accidents, alcoholism, disability, emotional aspects of occupational dermatoses and industrial intoxications, psychosomatic and other problems.

Physicians interested in attending this course should write for an application blank to Secretary, Institute of Industrial Health, Kettering Laboratory, Eden and Bethesda Avenues, Cincinnati 19, Ohio. Early application is advised since attendance will be limited.

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Harvard public health scholarships

Scholarships for the Academic Year 1957-58 will be granted to individuals of high professional promise in awards ranging from part tuition to tuition plus a stipend, according to the qualifications and financial needs of the applicants. The Scholarship Funds are limited and are primarily intended for citizens of the United States. In general, preference will be given to applicants under 35 years of age.

Scholarships are available to those in the following categories who wish to obtain post-graduate education in the field of public health or in one of the basic sciences related to public health: Physicians, Dentists and Veterinarians; Industrial Physicians; Public Health Nurses with a college degree and satisfactory field experience; Social Workers with a master's degree from an approved school of social work and acceptable experience in the field of medical or psychiatric social work; Health Educators with a college degree, training either in health education or in the natural and social sciences and experience in general education or community health work; Dietitians with a college degree and satisfactory field experience; College Graduates who have concentrated in one of the Natural Sciences or in Engineering (environmental aspects), for example, Biologists, Biochemists, Nutritionists, Microbiologists, Parasitologists or Biostatisticians.

Scholarship applicants must be eligible for admission to the School as a candidate for one of the following degrees: Master of Public Health, Doctor of Public Health, Master of Science in Hygiene, Doctor of Science in Hygiene, Master of Industrial Health.

A catalogue of the school, admission and scholarship applications, and further information may be obtained by writing to the Secretary of Admissions and Scholarships, Harvard School of Public Health, 55 Shattuck Street, Boston 15, Massachusetts.

Scholarship applicants must return completed admission and scholarship applications to the Harvard School of Public Health by March 1, 1957. Scholarship awards will be announced May 1, 1957. Under exceptional circumstances awards will be made at other times.

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World war II history of orthopedic surgery

Orthopedic injuries — injuries to the bones and joints — made up the largest single group of casualties in World War II, Army Surgeon General Silas B. Hays points out in a foreword to the first volume of the Army Medical Service's history of orthopedic surgery in World War II.

"Orthopedic Surgery in the European Theater of Operations" is the eighth in the Army Medical Service's clinical series. It was written by the former senior consultant in orthopedic surgery in the Theater, Dr. Mather Cleveland, former Colonel, Medical Corps, and now practicing orthopedic surgeon in New York City, and Dr. Marshall Urist, former Major, Medical Corps now associate clinical professor of surgery, division of orthopedics, University of California.

The authors were assisted in the preparation of this book by information supplied by all junior consultants in orthopedic surgery in the European Theater, and many chiefs of section, relating their experiences in the care of wounds and injuries of the bones and joints.

According to the former chief surgical consultant in the European Theater, the late Dr. Elliot C. Cutler, who at the termination of World War II was a Brigadier General, Medical Corps, the material brought together here "will be of value not only to the military surgeon but to those interested in bone and joint surgery in civil life.

"The proper handling of the combined major nerve injury and the compound fracture was varied and unsatisfactory until the experience of the recent war," Dr. Cutler wrote. "Now, as can be learned by those who turn the pages of this volume, this difficult problem is settled and can be taught to the growing generation of doctors as a final, useful part of their education."

Dr. Cleveland, in his introduction to the volume states that, "If the medical histories of World War II incorporate the clinical experiences of that war and if what is printed will be read in the future — as it has not always been read in the past — military surgeons will not, in the future, repeat the mistakes of the past, as they did in World War II."

The World War II history of orthopedic surgery will be completed by two forthcoming volumes, "Orthopedic Surgery in the Mediterranean Theater" and "Orthopedic Surgery in the Zone of Interior."

All volumes in the Army Medical Service clinical series are prepared in the Historical Unit, Army Medical Service, of which Col. John Boyd Coates, Jr., is Editor in Chief. "Orthopedic Surgery in the European Theater of Operations" may be obtained from the Superintendent of Documents, Government Printing Office, Washington 25, D. C. at a cost of $4.00.

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AT THE EDITOR'S DESK



James Andrews, Jr., Director of Health Insurance of the Life Insurance Association of America, believes that major medical insurance is the key to the problem of modern health care economics. It provides benefits up to a maximum limit of $5,000, $7,500, or $10,000. The two characteristic features are a deductible amount to eliminate payment of small bills and a coinsurance provision by which the insurance company pays 75 per cent, 80 per cent, or more of the expenses of treatment up to the benefit limit of insurance. Major medical insurance now provides protection for more than 5.2 million people.

A new dental insurance plan was announced recently by Group Health Dental Insurance Inc. It will pay any dentist anywhere in the world for services rendered to its subscribers.

A new combination X-ray and chemical treatment of cancer was announced recently by the American College of Radiology. Two of the chemicals are antivitamins capable of limiting the growth of both healthy and cancerous cells. The third is an antipurine that reduces the ability of the cells to synthesize nucleic acids. When these chemicals were administered to mice with mammary cancer, the tumor disappeared after X-ray therapy was applied. This does not occur when X-ray and the chemicals are used independently.

Several months ago your editor mentioned that the manufacturers of bioflavonoids hoped to tap the multimillion dollar common cold market. The going has been tough because the A.M.A. has refuted a favorable report that appeared in the November issue of the Journal of Industrial Medicine and Surgery. Dr. W. L. Macon, Jr. used bioflavonoids on workers in an industrial plant and reported that the number of absences due to respiratory ailments decreased 10 per cent; and the average man-hour loss from colds was reduced by 15 per cent. The November 24 issue of the Journal of the American Medical Association carries two articles on the use of bioflavonoids in the common cold, one involving over 1,900 subjects and the other, 89 medical students. The reporting physicians found bioflavonoids of no value in altering the course of the cold or shortening its duration. The battle is now in the hands of the public relations department. It is too bad physicians are caught in the middle of a controversy of this nature. The situation demonstrates the extent drug houses will go to advertise their product to the public.

W. D. Paul, of Iowa City, found that two aspirin tablets at bedtime tend to induce sleep. If more physicians recommended this simple remedy, it might help to minimize the public's increasing addiction to sleeping potions.

Physicians are disturbed about the ability of certain disease-causing organisms to develop resistance to drugs. The solution, according to Sir Howard Florey, "is the development of new

drugs along with more discriminating use of existing antibiotics and, if necessary, the long-term abandonment of certain drugs."

It was encouraging to hear that the mortality from all types of cancer was down by 13 per cent for women at ages 45-64 over a 10 year period. Deaths from uterine cancer declined by one-third. For the second time a Federal court has determined that the Hoxsey medicines for internal cancer are worthless. At the trial there was testimony concerning persons who may have died of cancer as a result of reliance upon the Hoxsey treatment, instead of seeking competent medical treatment in the early stages of their condition.

According to a recent A.M.A. report, five medical schools have an enrollment in excess of 600. The largest is the University of Tennessee, with 781 students. The University of Michigan followed with 762; Jefferson at Philadelphia, 677; University of Illinois, 636; and the University of Texas at Galveston, 614.

Drive-in medical offices are planned atop an office building-bus terminal in New York City. Special elevators will carry driver-patients in their own cars to a rooftop parking area with space for 125 cars.

A new antirabic vaccine that produces immunity was reported by Dr. John P. Fox, of Tulane University. Antibodies developed within 10 days of vaccination in 90 per cent of 35 patients. The new HEP-Flury vaccine is prepared from chick embryos injected with an attenuated virus and is given intradermally at five day intervals.

A new attractive and durable electric toothbrush was announced recently by the Barrett Division, Allied Chemical and Dye Corp. It is designed to safeguard sensitive gums and encourage proper brushing technique. It has interchangeable heads to permit use by the entire family.

Compazine is S.K.F.'s new tranquilizer and antiemetic. The drug is a possible successor to Thorazine and is said to be effective in nausea and vomiting, the menopausal syndrome, many psychophysical disorders, and depressions, especially those associated with moderate neurotic and senile conditions.

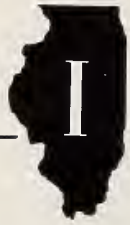
A sample of English humor: when I told Punicus that I get a pain in the back not only from gardening but also from thinking about gardening, I am sorry to say that his reply was "Hortosuggestion, old man."

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Hallucinogens

Fabing, in discussing the chemotherapy of certain psychoses, refers to a number of psychonoxious drugs, known to the Germans as "phantastica" and, more recently, as "hallucinogens." In his study of these drugs, Fabing found that an indole nucleus is common to their chemistry. The substances of vegetable origin include LSD-25 from rye rust, yohimbine, mescaline, and others. There also are hallucinogens of animal origin. These include trptamine, bufotenene, adenochrome (pink adrenalin), and others. Although these drugs cause schizophrenic-like reactions, and do not seem to enter into the production of depressions, in my opinion it is conceivable that other chemical compounds not yet discovered are in some way involved in the causation of depressive reactions. *Gordon R. Kamman, M.D. Harmful Effects of Interpretive Psychotherapy in Certain Involutional Depressions. Minnesota Med. July* 1956.

NEWS of the STATE



ADAMS

Personal.—Dr. James R. Cooper returned to Quincy, November 15, after completing a two year tour of duty with the U. S. Air Force.—Dr. William U. McReynolds, Quincy, has been named a diplomate of the American Board of Ophthalmology.

COOK

Ninty-Five Years Young.—Dr. Katharine Swartz observed her ninety-fifth birthday, November 23, at a small gathering in the home of a niece, Mrs. Walter J. Meyer. Dr. Swartz stated that the best philosophy is to "make a hobby of being kind to everyone".

Adrien Ver Brugghen Goes to Nevada.—Dr. Adrien Ver Brugghen, prominently identified with numerous activities in Chicago for many years, has moved to Las Vegas, Nevada, where he is engaged in neurological surgery and neurology. His address is 2020 West Charleston Street, Las Vegas.

Institute of Medicine Honors Four Citizens.—The Institute of Medicine of Chicago honored four citizens at the recent annual meeting for their contributions to community welfare. They are Frank J. Lewis, financier; Miss Mary E. Westphal, superintendent emeritus of the Visiting Nursing Association of Chicago; Edward Foss Wilson, president of the American Cancer Society's Illinois division, and Mrs. Alfred D. Kohn, pioneer welfare worker. The institute reelected Drs. Warren H. Cole, Ernest G. McEwen and Walter H. Theobald to five year terms on the board of governors.

Personal.—Dr. Lowell T. Coggeshall, dean of biological sciences at the University of Chicago School of Medicine and Assistant Secretary of the Department of Health, Education and Welfare, was named president-elect of the Association of American Medical Colleges recently. Dr. Dean F. Smiley, Evanston, was reelected executive secretary.—Dr. Herbert E. Schmitz, chairman of the department of obstetrics and gynecology, Stritch School of Medicine, Loyola University, was elected president of the Central Association of Obstetricians and Gynecologists during its recent meeting in New Orleans.

Surgeons and the Rise of Anatomy.—Dr. Ilza Veith, professor of the history of medicine, University of Chicago School of Medicine, and president of the Chicago Society of Medical History, will deliver the fifth in a series of lectures on the history of surgery at the International Surgeons Hall of Fame, Chicago, January 29. Dr. Veith's subject will be "Surgeons and the Rise of Anatomy." The lectures are sponsored by the International College of Surgeons' School of the History of Surgery and Related Sciences. They are open to physicians, medical technicians and students and the public. Reservations should be made through Miss Margaret Lehman at the college, 1524 Lake Shore Drive, Chicago 10, Illinois.

The Leo Kaplan Lecture.—Dr. Theodore Lidz, professor of psychiatry, Yale University School of Medicine, New Haven, gave the Dr. Leo A. Kaplan Memorial Lectureship in Neuropsychiatry, November 29, at the Drake Hotel, under the auspices of the Phi Delta Epsilon Foundation of Chicago. The title of his talk was "Influence of Psychosomatic Concepts on General Medicine."

Dr. Luken Observes Fiftieth Anniversary.—Dr. Martin G. Luken and some of his patients sat down, November 16, to cut an anniversary cake marking the fiftieth anniversary of his service as physician to the children of Angel Guardian orphanage. According to the Chicago Tribune, Dr. Luken sort of inherited the chore from his uncle, the late Dr. Martin H. Luken, who started treating the young patients in the orphanage in 1871, six years after its founding. Between Dr. Luken and his uncle, the family has given the institution eighty-five years of service. Dr. Luken still maintains a private practice

and serves as medical board chairman at St. Elizabeth's hospital.

Dickinson Lecture.—"Is Food Making You Sick?" was the title of the talk by Dr. James R. Wilson, Winnetka, at the Chicago Academy of Sciences, November 28. This was the Fifth Albert Dickinson Memorial Lecture which is open to the public and is in the general field of nutrition. The series is dedicated to Albert Dickinson whose bequest made possible the auditorium bearing his name.

Fund To Maintain Heart Conference.—A check for $25,000 to maintain the Heart in Industry conference for the next five years was given to the Chicago Heart Association as a memorial to Gustav Freund II, former manufacturer, who died October 26. The check was presented to Dr. Louis N. Katz, president of the Chicago Heart Association, during the fourth heart conference in the Morrison Hotel, November 28.

Dearholt Medal Awarded.—Herbert C. De Young, past president of The Institute, was recently awarded the Dearholt Medal for outstanding contribution to tuberculosis control at the annual Mississippi Valley Conference on Tuberculosis in Detroit. De Young, the second Chicagoan to receive the award in its 15-year history, was president of The Institute from 1946 to 1956. He is serving his twentieth year as a member of the board of directors. The award is presented in the name of the late Dr. Hoyt Dearholt, a pioneer in the tuberculosis control movement in Wisconsin.

The Chicago Regional Committee on Trauma.—The Chicago Regional Committee on Trauma of the American College of Surgeons will conduct an intensive course on fractures and other trauma, April 10-13, 1957, at the John B. Murphy Auditorium, 50 East Erie Street, Chicago. Lectures and demonstrations will be conducted by surgeon-teachers of the Chicago area. Subjects will include: bony trauma; soft tissue trauma, vascular injuries, bone grafting, traction technic, industrial casualties, farm injuries, auto crash injuries, burns, amputations, head injuries and others. The course is being given under the direction of Dr. Sam Banks.

Neurologists Choose Officers.—At a recent meeting of the Chicago Neurological Society, Dr. Irving C. Sherman was elected president; Dr. Ernst Haase, vice president; Dr. Adrien Ver Brugghen, councilor, and Dr. Oscar Sugar, 912 South Wood Street, Chicago 12, secretary.

Dr. Stenhouse Honored.—Dr. Evangeline E. Stenhouse, attending dermatologist at the Women and Children's Hospital, where she has had a dermatology clinic for fifteen years, recently received the Elizabeth Blackwell annual award from the American Medical Women's Association. The award honors the memory of the first woman physician in America.

Society News.—On December 4, the North Shore Branch of the Chicago Medical Society presented a program in cooperation with the Chicago Heart Association. Speakers were Drs. George Stephenson, assistant professor of pathology, Northwestern University Medical School, on "New Laboratory Aids In Diagnosis," and Joseph R. Christian, associate professor of pediatrics, Stritch School of Medicine of Loyola University, on "Rheumatic Fever Prevention."—Dr. Angelo P. Creticos addressed the Harvey Chamber of Commerce, November 29, on "Rehabilitating the Cardiac." He spoke before the Chicago Chapter of Medical Social Workers, December 5, on "Tranquilizing Drugs." The addresses were under the sponsorship of the Chicago Heart Association and the Rehabilitation Institute of Chicago, respectively.

In Memory of Kellogg Speed.—On December 14, the Chicago Orthopaedic Society presented a program honoring the memory of Dr. Kellogg Speed, honorary member of the society and founding member of the American Board of Orthopaedic Surgery, who died July 2, 1955. Dr. Arthur H. Conley spoke on "Dr. Speed, the Rebel." "Swivel Ball Hip Prosthesis" was discussed by Dr. Carlo S. Scuderi, "Dislocations of the Shoulder" by Dr. James J. Callahan, and "Various Uses of the Kuntscher Nail" by Dr. Horace E. Turner.

Symposium on Parenteral Therapy with Fluids.—A symposium on parenteral therapy with fluids, co-sponsored by the Chicago Medical Society and Baxter Laboratories, Inc., was held at the Sheraton Hotel, December 5-6, in connection with the twenty-fifth anniversary of Baxter Laboratories and pioneering by Chicago physicians in the development of such therapy. The program, which opened with a review of the development of parenteral therapy with fluids by Dr. Karl A. Meyer, president, Chicago Medical Society, included the following: Harry F. Weisberg, Chicago, on "Physiology of Acid Base Balance;" Harvey R. Bernard, St. Louis, on "Diagnosis of Fluid Electrolyte Imbalance;" Parker Vanamee, New York City, on "Third Body Space —Translocation of Fluid;" Charles U. Lowe, Buffalo, on "Special Pediatric Problems;" Carl O. Rice, Minneapolis, on "Therapy of Fluid Electrolyte Problems;" Ralph M. Hartwell, New Orleans, on "Use of Blood;" Jacob J. Weinstein, Washington, D.C., On "Use of Plasma Volume Expanders;" Major Bruce G. MacMillan, M.C., Brooke Army Medical Center, Fort Sam Houston, Texas, on "Treatment of Burns;" Rachmiel Levine, Chicago, on "Carbohydrates;" Tom D. Spies, Birmingham, on "Vitamins;" William E. Abbott, Cleveland, on "Protein" and Frederick J. Stare, Boston, on "Fat."

Police Educated to Recognize Insulin Shock.—A year round education program is being conducted by the Chicago Diabetes Association in an effort to alert police trainees to the symptoms of insulin reactions. Jail lockup keepers and matrons are also attending the session, according to the Chicago Tribune, November 15. The program is under the direction of Dr. Jerome T. Paul, associate professor of medicine, University of Illinois College of

Medicine, and secretary of the diabetes group. The newspaper report indicated that police are instructed to take all persons picked up in an unconscious state to a hospital for diagnosis or to a physician for an examination instead of putting the suspected alcoholic or addict in jail "to sleep it off." Recruits are taught how to distinguish insulin equipment—needles and syringes—from that used by a drug addict. The program includes instruction on the detection of insulin reaction symptoms other than unconsciousness. In the case of a particularly belligerent or uncooperative person who might be picked up for causing an accident or for committing a traffic violation police have been told that belligerency may be a part of the reaction and are asked to watch for this condition, the newspaper stated. According to Dr. Paul, the program should allay fears among diabetics of being picked up by the police and put in jail away from vitally important medical care which could mean life or death to them.

DUPAGE

Society Election.—Dr. Harry G. Hardt, Jr. Elmhurst, was elected president of the DuPage County Medical Society, November 15, succeeding Dr. William Bretz, Hinsdale. Dr. Earl Hathaway, Villa Park, was elected vice president, and Dr. Samuel K. Lewis, was reelected secretary-treasurer.

Dr. Lewis Reelected Coroner.—Dr. Samuel K. Lewis not only was reelected coroner in the November 6 election, but he was accorded the highest vote of any candidate for county office, according to the DuPage Press, November 19.

FULTON

Dr. Coleman Honored.—The Western Surgical Association recently elected Dr. Everett P. Coleman, Canton, as its president for the forthcoming year. Dr. Coleman is a Past President of the Illinois State Medical Society.

LAKE

New Members.—Dr. Gilbert Lanoff has transferred his membership from the Chicago Medical Society to the Lake County Medical Society. Dr. Frank Mazeika has been elected into membership of the latter society.

Christmas Party.—Abbott Laboratories sponsored the social hour preceding the Annual Christmas Party of the Lake County Medical Society in the Rustic Manor, Gurnee. The election of officers took place at this meeting.

SANGAMON

Society News.—"Trauma to the Hand" was the subject of Dr. John L. Bell, Chicago, before the Sangamon County Medical Society at its dinner meeting in the Elks Club, Springfield, December 6. Dr. Bell is associate professor of surgery at Northwestern University Medical School.

VERMILION

Society News.—At the November 6 meeting of the Vermilion County Medical Society at the Hotel Wolford, Danville, Dr. Isadore Dyer, professor of obstetrics at Tulane University of Louisiana School of Medicine, New Orleans, spoke on "Post-Cesarean Hysterectomy."

WARREN

Society News.—Dr. F. Garm Norbury, Jacksonville, past president of the Illinois State Medical Society, addressed the Warren County Woman's Club at Monmouth College recently, on "Mental Health."

Dr. Firth and Forty and Eight Help Student Nurses.—Dr. John O. Firth, Monmouth, gave several talks recently on the shortage of nurses in Illinois and the work of the Forty and Eight, a division of the American Legion in providing funds to finance the students who otherwise could not have continued toward this professional goal. Dr. Firth spoke to groups in Pekin, Canton and Princeton.

WILL-GRUNDY

Ed Uzemack Addresses Medical Meeting.—Edward A. Uzemack, director of public relations and assistant secretary of the Illinois State Medical Society, Chicago, addressed the Shreffler Memorial Medical meeting in Joliet, December 11, on "Public Relations in Medicine." Mr. Uzemack also presented the recent AMA study on What the American People Think of the Medical Profession. This Shreffler Memorial medical meeting is attended by some fifty physicians who meet once a month to obtain general and medical knowledge and, at the same time, strengthen medical cooperation.

WINNEBAGO

New Members.—Dr. Henry C. Anderson and Dr. John C. McPherson were elected to active membership, October 12, in the Winnebago County Medical Society. On October 26, Dr. Philip E. Pemberton was elected to associate membership. Dr. Anderson's address is 4415 Charles Street, Rockford; Dr. McPherson, Medical Arts Building, 1335 Charles Street, Rockford; and Dr. Pemberton is a resident in pathology at Rockford Memorial Hospital.

Blood Bank Expands.—The Northern Illinois Blood Bank has recently expanded its field of operation and now services Winnebago, Boone and Ogle Counties, according to the Bulletin of the Winnebago County Medical Society. Since its inception, the Blood Bank has been housed in the late Dr. E. H. Weld's building, 307 North Main Street. In order to expand, it became necessary to have larger quarters and the Blood Bank now occupies the entire second floor of the building. Reconstruction has been going on for some time. When it is completed, there will be four donor rooms rather than the two donor rooms which have been used in the past. The canteen has also been made much larger and a lounge has been provided.

GENERAL

School Health Week in Chicago.—In an official proclamation, dated November 5, 1956, Mayor Richard J. Daley proclaimed the week of April 1-5,

1957, as "School Health Week In Chicago." Following is the exact resolution:

WHEREAS, the health of the school child is of prime importance to the community; and

WHEREAS, the school child of today is the adult citizen of tomorrow; and

WHEREAS, a healthy adult population is best established in childhood;

NOW, THEREFORE, I, Richard J. Daley, Mayor of the City of Chicago, do hereby proclaim April 1-5, 1957, "SCHOOL HEALTH WEEK IN CHICAGO" to provide opportunity for parents, teachers, clergymen, schools and cooperating health, allied and civic agencies to promote a concentrated educational program on the health of the school child.

The project is being developed under the auspices of the Joint Committee on School Health Services of Chicago and a coordinating committee representative of all groups allied with this committee. Five schools will be chosen in the Chicago area for certain specific programs and open house for parents. While these five schools will be centers for concentrated programs, it is hoped that all schools in the Chicago area will be active in devoting special attention to "School Health Week."

New Guide to Ethical Hospital-Press-TV-Radio Relationships.—The Chicago Hospital Council, an organization of 63 hospitals in the metropolitan area, released its new "Guide to Ethical Hospital-Press-TV-Radio Relationships" at a dinner for the press on November 14. The "Guide" states the rights and requirements of the news media and the news sources on stories originating in hospitals, and proclaims that they are recognized and accepted by both parties. It was developed by a joint committee of hospital representatives and newsmen after more than a year of negotiations. The Chicago Medical Society, as well as the Chicago Hospital Council, has concurred with its principles. Press representatives on the Joint Committee are: Edward H. Eulenberg, City News Bureau; Maury Falstein, Sun-Times; Roy Gibbons, Chicago Tribune; Sam H. Saran, National Broadcasting Company; C. Owsley Shepherd, American; Arthur J. Snider, Daily News. Members representing hospitals are: G. Norman Andrews, assistant director, Blue Cross Plan for Hospital Care, Chairman; Clyde L. Reynolds, Executive Director, Provident Hospital; and John R. Kinsey, public relations director, Chicago Wesley Memorial Hospital.

New Officers.—Dr. A. I. Doktorsky was named president-elect of the Illinois Academy of General Practice, November 13. Dr. Orvan A. Phipps, Manteno, succeeds Dr. George S. Schwerin, president, and Dr. Harry Marchmont-Robinson, Evergreen Park, was reelected executive secretary.

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:

Walter L. Oblinger, Springfield, Associate Counsel, Illinois State Medical Society, Aux Plaines Branch of the Interprofessional Council in Oak Park, November 28, on Operation Legislation.

Edward S. Burge, Evanston, assistant professor of obstetrics and gynecology, Northwestern University Medical School, Maine Township High School Adult Evening School Class in Des Plaines, February 4, on Problems of the Menopause.

Harry E. Rice, Jr., member of the staffs of St. Charles, Copley Memorial and St. Joseph's Mercy Hospitals, Aurora, Maine Township High School Evening School Class, February 11, on Hypertension.

Paul J. Dunn, clinical instructor in pediatrics, Stritch School of Medicine of Loyola University, St. Edmunds School Mothers Club in Oak Park, February 12, on Feeding Problems.

Caesar Portes, assistant clinical professor of proctology, Chicago Medical School, Maine Township High School Adult Evening Class, February 18, on Cancer.

Louise Tavs, clinical assistant professor of dermatology, University of Illinois College of Medicine, Maine Township High School Adult Evening Class, February 25, on Diseases of the Skin.

John O. Firth, Monmouth, coroner of Warren County, Henry County Home Economics Association in Cambridge, February 27, on The Antibiotics.

Lectures Arranged Through the Committee on Postgraduate Medical Education and Scientific Service:

Bert I. Beverly, Oak Park, instructor in pediatrics, Northwestern University Medical School, Knox County Medical Society in Galesburg, December 20, on Pediatric Emergencies Seen in General Practice.

Walter C. Bornemeier and Frederick W. Slobe, both of Chicago, members of the Committee on Medical Economics, Illinois State Medical Society, Will-Grundy County Medical Society in Joliet, January 10, on The Pro and Con of Social Security.

James W. Merricks, Chicago, clinical associate professor of surgery (urology), University of Illinois College of Medicine, Knox County Medical Society in Galesburg, January 17, on Urinary Bladder Substitutes.

William L. Riker, Chicago, pediatric surgeon, Children's Memorial and Grant Hospitals, Englewood Branch of the Chicago Medical Society, February 5, on Pediatric Heart Surgery.

Philip Thorek, Chicago, assistant professor of surgery, University of Illinois College of Medicine, Rock Island County Medical Society in Moline, February 12, on Do's and Don'ts in General Surgery.

Percy E. Hopkins, Chicago, Chairman of the Committee on Medical Service and Public Relations, Illinois State Medical Society, Will-Grundy County Medical Society in Joliet, February 14, on Medicare.

Thomas F. Kruchek, Chicago, clinical assistant in psychiatry, Stritch School of Medicine, Stock Yards Branch of the Chicago Medical Society, February 15, on Value of Tranquilizing Agents.

Peter J. Talso, Chicago, associate professor and assistant chairman of the department of medicine, Stritch School of Medicine of Loyola University, Kankakee County Medical Society in Kankakee, February 19, on Collagen Diseases.

DEATHS

John M. Bick*, Chicago, who graduated at Northwestern University Medical School in 1897, died November 2, aged 89.

Ellis Bonnell, Blue Island, who graduated at the University of Illinois College of Medicine in 1934, died August 22, aged 47, of coronary thrombosis. He was a member of the American Psychiatric Association.

Arthur Henry Bitter*, Quincy, who graduated at the University of Pennsylvania School of Medicine, Philadelphia, in 1918, died November 24, aged 64. He had served as secretary and president of the Adams County Medical Society and chief of staff at both Blessing and St. Mary's Hospitals.

Charles F. Brian*, Bellmont, who graduated at Barnes Medical College, St. Louis, in 1905, died November 25, aged 80. He was a member of the "Fifty Year Club" of the Illinois State Medical Society.

French S. Cary, retired, Chicago, who graduated at the College of Physicians and Surgeons of Baltimore in 1906, died December 11, aged 77. He was a past president of the Chicago Urological Society.

John P. Coughlin*, Evanston, who graduated at Loyola University School of Medicine in 1917, died November 21, aged 66.

Elbert Leroy Damron*, Effingham, who graduated at St. Louis College of Physicians and Surgeons in 1907, died in the Veterans Administration Hospital, Hines, August 5, aged 76, of cancer.

Michael F. Dorsey*, retired, Chicago, who graduated at Rush Medical College in 1900, died November 29, aged 84. He had practiced medicine for 50 years in Streator before he retired and came to Chicago.

William Held, Chicago, who graduated at Jenner Medical College, Chicago, in 1902, died November 13, aged 79.

Gaylord Ray Hess*, Chicago, who graduated at Rush Medical College in 1918, died in Milwaukee, September 2, aged 66.

Benjamin M. Levin*, Chicago, who graduated at the University of Illinois College of Medicine in 1924, died November 27, aged 58. He was associate professor of pediatrics at the Chicago Medical School.

Thomas F. Maher, retired, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1906, died November 26, aged 79.

Robert Campbell Menzies, Chicago, who graduated at Rush Medical College in 1905, died September 23, aged 74.

Robert B. Nyberg, Galatia, who graduated at St. Louis University School of Medicine in 1905, died November 18, the day before his 77th birthday. He was one of the founders of the Harrisburg Hospital.

Arthur White Ogden*, retired, Joliet, who graduated at the Hahnemann Medical College and Hospital, Chicago, in 1913, died August 17, aged 72, of arteriosclerotic heart disease.

Kurt W. Ossendorff*, Chicago, who graduated at Ludwig-Maximilians-Universität Medizinische Fakultät, München, Bavaria, in 1911, died November 23, aged 70. He was a member of the staffs of Alexian Brothers, Columbus and St. John's Hospitals; director and past president of the German Medical Association of Chicago and Alexian Brothers Hospital Foundation.

Joseph Rubenstein*, Chicago, who graduated at the University of Illinois College of Medicine in 1925, died December 7, aged 55. He served in the Medical Corps of World War II.

Edward C. Sheehan*, Oak Park, who graduated at Loyola University School of Medicine in 1934, died November 20, aged 47. During World War II he served with the Army Medical Corps in North Africa and Italy.

Edward Trippel*, O'Fallon, who graduated at St. Louis University School of Medicine in 1912, died August 22, aged 67, of diabetes mellitus.

William J. Vopata*, Riverside, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1904, died recently, aged 76.

William Zimmermann*, retired, Quincy, who graduated at Washington University School of Medicine, St. Louis, in 1897, died recently, aged 83.

*Member of the Illinois State Medical Society.

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BOOK REVIEWS



Pediatrics edited by Donald Paterson, M. D. Formerly Clinical Professor, Department of Pediatrics, The University of British Columbia and John Ferguson McCreary, M. D., Professor and Head, Department of Pediatrics, The University of British Columbia. With 36 Contributing Authors. J. B. Lippincott Company, Philadelphia, Montreal. 654 pps. $14.00.

This addition to the field of pediatric literature has the happy and unusual faculty of increasing the reader's interest as he reads it further. It is written, not in that style so common today, of a tired instructor lecturing to a bored class, but in short concise, excellently constructed English. Polysyllabic words are not found where shorter words will serve.

The material is arranged by systems in the usual manner, with additional chapters on juvenile gynecology, adolescent problems, public health services and pediatric orthopedics. The chapter on tuberculosis merits individual praise.

The bibliographies at the end of each chapter are brief but entirely adequate. The illustrations are clear and self-explanatory and the various tables are revealing but not confusing.

This book impresses one as having been written by doctors wishing to teach and inform the busy practitioner, and not by men overwhelmed by a desire to see themselves in print. It is recommended for all who care for children.

J. C. McK.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

The Happy life of a Doctor. By Roger I. Lee, M.D., (Autobiographic) Little, Brown and Company, Boston. Price $4.00.

The Visual Fields. A Textbook and Atlas of Clinical Perimetry. By David O. Harrington, A.B., M.D., F.A.C.S., Clinical Professor of Ophthalmology, University of California School of Medicine; Consultant in Ophthalmology, U.S. Veterans Administration Hospital, Fort Miley, San Francisco, Calif. With 234 Illustrations and Nine Color Plates. The C. V. Mosby Company, St. Louis, 1956. Price $16.00.

Rehabilitation Literature, 1950-1955. Compiled by Earl C. Graham, Librarian, and Marjorie M. Mullen, Assistant Librarian, National Society for Crippled Children and Adults. The Blakiston Division. McGray-Hill Book Company, Inc., New York-Toronto-London, 1956. Price $13.00.

Educating Spastic Children—The Education and Guidance of the Cerebral Palsied. By F. Eleanor Schonell, M. A., Ph. D., Formerly research fellow, University of Birmingham, Department of Pediatrics and Child Health. Philosophical Library, Publishers, 15 East 40th Street, New York. 16, New York. $6.00.

Organized Home Medical Care in New York City—A Study of Nineteen Programs by the Hospital Council of Greater New York. Published for the Commonwealth Fund by Harvard University Press, Cambridge, Massachusetts, 1956. $8.00.

Practical Pediatric Dermatology. By Morris Leider,

(*Continued on page 58*)



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In the light of recent research,* the traditional raising of a glass of good cheer—"To Your Good Health"—has become more than just a symbol of good fellowship.

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Wine for Gentle Sedation—Described as the safest of all sedatives, wine can be used to dispel the fears and anxieties of old age and of prolonged illness. The judicious use of dessert wine at bedtime can often induce normal sleep without the use of drug medication.

Wine to Brighten the Sick Tray—In the dull and often unappealing dietary regimen of many patients, a glass of wine can frequently provide a touch of interest and "elegance"—a psychological boost of inestimable value—and for just a few cents a day.

The Flavorsome Fine Wines of California—The fine wines of California are delicious, and the variety is so wide that a wine can be found to suit individual taste.

*Uses of Wine in Medical Practice, published by Wine Advisory Board, 717 Market Street, San Francisco, California.



1. Goetzl, F.R.: Permanente Found. M. Bull. *8*:72 (April) 1950.

2. Irvin, D.L., and Goetzl, F.R.: Permanente Found. M. Bull. *9*:119 (Oct.) 1951.

3. Irvin, D.L.; Durra, A., and Goetzl, F.R.: Am. J. Digest. Dis. *20*:17 (Jan.) 1953.

4. Goetzl, F.R.: A Note on the Possible Usefulness of Wine in the Management of Anorexia, unpublished.

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BOOKS RECEIVED (Continued)

M. D., Associate Professor of Dermatology and Syphilology, New York University Post-Graduate Medical School. 280 photographs and 13 drawings. The C. V. Mosby Company, St. Louis, 1956. $10.50.

THE RECOVERY ROOM—Immediate Postoperative Management. By Max S. Sadove, M. D., James H. Cross, M. D., With contributions by 24 authorities. 597 pages. Illustrated. W. B. Saunders Company, Philadelphia and London, $12.00.

CLINICAL EXAMINATIONS IN NEUROLOGY. By members of the Sections of Neurology and Section of Physiology, Mayo Clinic and Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota, Rochester, Minnesota. 370 pages. 76 figures. W. B. Saunders Company, Philadelphia and London, $7.50.

THE MANAGEMENT OF FRACTURES, DISLOCATIONS AND SPRAINS. By John Albert Key, B. S., M. D., F. A. C. S., St. Louis, Missouri, Clinical Professor Emeritus of Orthopedic Surgery, Washington University School of Medicine; Associate Surgeon, Barnes, Children's and City Hospitals, and H. Earle Conwell, M. D., F. A. C. S., Birmingham, Alabama, Associate Professor of Orthopaedic Surgery, University of Alabama School of Medicine; Associate Orthopaedic Surgeon, University Hospital. Sixth edition. The C. V. Mosby Company, St. Louis, $20.00.

CARE OF THE LONG TERM PATIENT. Commission on Chronic Illness. Published for the Commonwealth Fund, by Harvard University Press, Cambridge, Massachusetts, 1956. $8.50.

CIBA FOUNDATION SYMPOSIUM ON PAPER ELECTROPHORESIS. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O. B. E., M. A., M. B., B. Ch. and Elaine C. P. Millar, A. H-W. C., A. R. I. C. 74 illustrations. Little, Brown and Company, Boston. $6.75.

DIABETES MELLITUS—Handbook for Physicians. By Howard F. Root, M. D., Sc. D., F. A. C. P., Medical Director of the Joslin Clinic, Boston, Lecturer in Medicine, Harvard Medical School. and Priscilla White, M. D., Sc. D., F. A. C. P., Joslin Clinic, Boston, Instructor in Pediatrics, Tufts University, Boston. Landsberger Medical Books, Inc., Distributed solely by The Blakiston Division of the McGraw-Hill Book Company. $7.00.

CIBA FOUNDATION SYMPOSIUM ON BONE STRUCTURE AND METABOLISM. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O. B. E., M. A., M. B., B. Ch. and Cecilia M. O'Connor, B. Sc. 121 illustrations. Little, Brown and Company, Boston. $8.00.

PRINCIPLES OF CLINICAL ELECTROCARDIOGRAPHY. By Mervin J. Goldman, M. D., Assistant Chief of the Medical Service and Cardiologist, Oakland Veterans Administration Hospital, Oakland. Lange Medical Publications, Los Altos, California. $4.50.

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Widening horizons

One of our major problems today is that our discovery of scientific truth has far outstripped our apprehension of spiritual truth. It is relatively easy for us to uncover scientific truths — it requires a certain exercise of intellect. But the desperate need of the world today is not for more intellect, more knowledge. The intellect is a good lieutenant but a bad captain. What is necessary, if men are to be set free as individuals and as nations, is a new grasp of spiritual truth, a spiritual renaissance, a new birth of spiritual power in every aspect of human thought and action. There is a burning need for dedicated men — men whose sole objective in life is to determine the truth — scientific and spiritual — which makes men free. In this respect we doctors have an unrivaled opportunity. The challenge to us is to self-dedication. We may, of course, remain humdrum and stick to our pills and penicillin. If so, we are "dabbling in the shallows when we could be swimming in the ocean." Medicine must have its spiritual pioneers no less than its scientific pioneers. To you at present, immersed in technical scientific studies but destined to explore these widening horizons of medicine, I would suggest three things.

1. All great literature, poetry, art, music, enlarges the human spirit and helps to build character — that is why it is great. Whenever a Beethoven writes a symphony he is expressing the experience of his spirit in a language whose technique he has mastered. We, without the technique, may catch his message and be enriched and enobled by it.

2. The wisdom of saints and seers is freely available. There is a spiritual library worthy of study as careful and exact as any we give to our professional textbooks. The library includes authors such as Thomas a Kempis, Henry Drummond, John Bunyan, Professor B. H. Streeter, and the recent writings of J. B. Phillips. It includes that portable library, the Bible.

3. The art of making men "whole" demands a shrewd combination of activism with quietism. To understand man's mind and spirit (including his own) the doctor must practice quietism; to understand and heal man's body he must be

(Continued on page 62)



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HORIZONS (Continued)

activist. We need, therefore, to meditate daily on great truths. In meditation, the horizontal plane of routine meets the vertical plane of eternal values. Such meditation, best undertaken in the morning, gives detachment, perspective, insight, and direction. It is the critical act that makes every day significant. It is a time which saves time, for it clarifies what is important. It adds to the day both direction and inspiration. As a daily habit it transforms the way you live, your ambitions, your interests, your methods. It emphasizes that the real purpose of life is spiritual development, since for every man, physical death is certain. Practiced by the seers for centuries, it is powerful today in the lives of those who learn to explore its secrets and who accept its discipline. It is essential now as never before, for it is potent in the upward struggle of mankind. Apart from extremely busy periods, the average doctor needs at least half an hour of such meditation daily; when exceptionally busy, he requires longer. Further, more than a personal religious faith is necessary. The atomic age also is the ideological age and, for the first time in history, a highly organized materialistic ideology has captured the minds and wills of one-third of the whole human race and is extending rapidly. Against so ominous a background, a religious faith devoid of the plan and passion of an ideology looks like a personal luxury. Moreover, medicine itself is in dire need of a dynamic new philosophy fed by deep spiritual roots. It is possible that, hampered by its upbringing and agnosticism, the profession as a whole will be unable to rise to this fundamental challenge of our times. It may, therefore, fall to you to discover and apply the spiritual ideology which is the only possible answer to contemporary materialism in all its forms. Without that spiritual ideology, man may disappear into the night of self-annihilation; with it, he will move confidently forward into the light of day. *R. W. Luxton, M.D. Medicine's Widening Horizons. Brit. M.J. Sept.* 1, 1956.

While tuberculosis is obviously an organic disease, it is just as clearly a social disease, taking its greatest toll among low-income, unskilled laborers suffering from overcrowded housing and poor nutrition. Rema Lapouse, M.D., Am. J. Pub. Health, August, 1956.



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Avoid anxiety with work

The anxiety states comprise the bulk of the psychiatric conditions in community and industrial medical practice. Although most of the people psychiatrists see in industry are so-called normal people they do have troubles and most of these troubles are on an anxiety basis. These are troubled workers. Most of their troubles come from off the job and are brought to the job, interfering with their production, their relationship to others, and with their health. The length of absence from work depends upon many variables such as personality structure, environmental stresses on and off the job, motivations for health and illness, secondary gains, and severity of the anxiety. I try to keep these people working because I know that the regular routine of the day's living and the day's working is better for them than idleness and preoccupation with self at home. Psychotherapy should be continued during this time. *Ralph T. Collins, M.D. Optimum Time Off from Work for Neurologic and Psychiatric Disabilities. Indust. Med. Sept.* 1956.

Don't I get a vote too?



Doctor, would it be helpful to you in your practice to know that there is a food available at reasonable prices in the stores the year round having these attributes:



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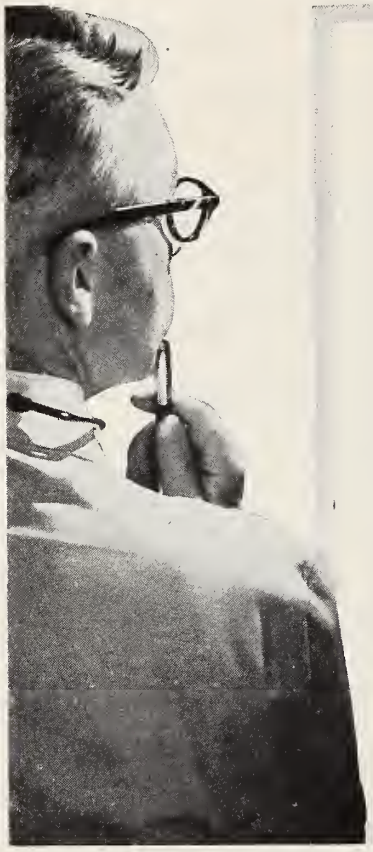
23. One of the easiest foods to eat or prepare.

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Poor economy

Medical directors of insurance companies and adjudication committees upon health and accident claims have their headaches; let's face this fact. But so also have those of us practicing physicians and surgeons who are trying to play a fair game of ball in making the ethical plans work. We may as well ignore the mail order, low premium, "appendectomy $50; all other operations $5" schemes. Also, we regret the occasional colleague who overcharges, pads his statements, and charges unnecessary assistant's fees. However, many of us are being penalized for honest efforts to conserve the funds of the better insurance organizations. A case in point is that of a small boy who caught his right hand in a wringer and was not rescued for 10 minutes. Digits were lost and deep palmar structures exposed. Amputation above the wrist could have been performed in one operation, but a valuable hand with good sensation and useful grasp was salvaged as a result of three reconstructive operations. His father pays for protection of his family against catastrophic medical, surgical, and hospital expenses by payroll deduction in a large corporation. The insurance carrier received a fair and carefully itemized bill, but granted only the price of one operation "because less than 90 days elapsed between the surgical procedures." Incidentally, the fee allowed was the same as for a child of similar age injured in farm machinery and given maximum surgical benefit by one relatively simple operation. The father of the former is prepared to stand up and be heard the next time he and his fellow workers meet together. He will call their attention to the apparent fact that they may not receive what they are paying for when a crisis comes. Cases of honest doubt and skepticism among our patients regarding prepaid health benefits are increasing. Despite good intentions of medical directors, fee schedules, and adjudication committees, they are missing a lot of boats in failing to come through upon legitimate and honest claims such as the above. Perhaps they should re-screen their participating physicians, more carefully scrutinize itemized bills, or occasionally call patient and/or doctor personally

(*Continued on page 70*)



The answer is

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If you would like

1. The authority for any of the statements made on the preceding page . . .
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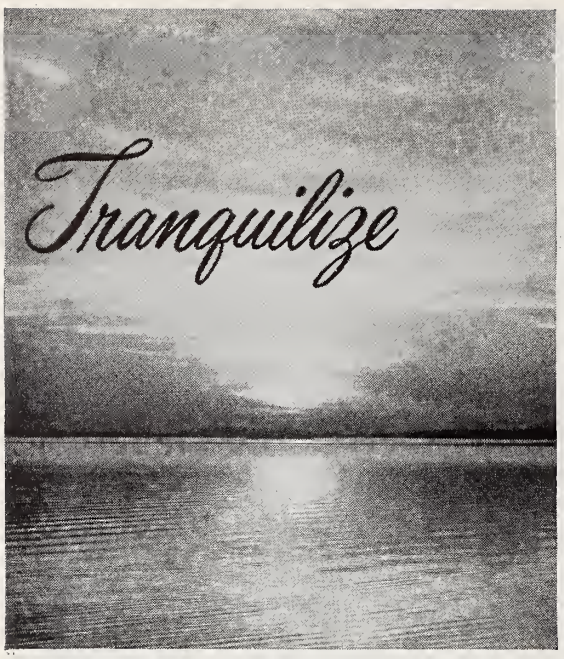
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ECONOMY (Continued)

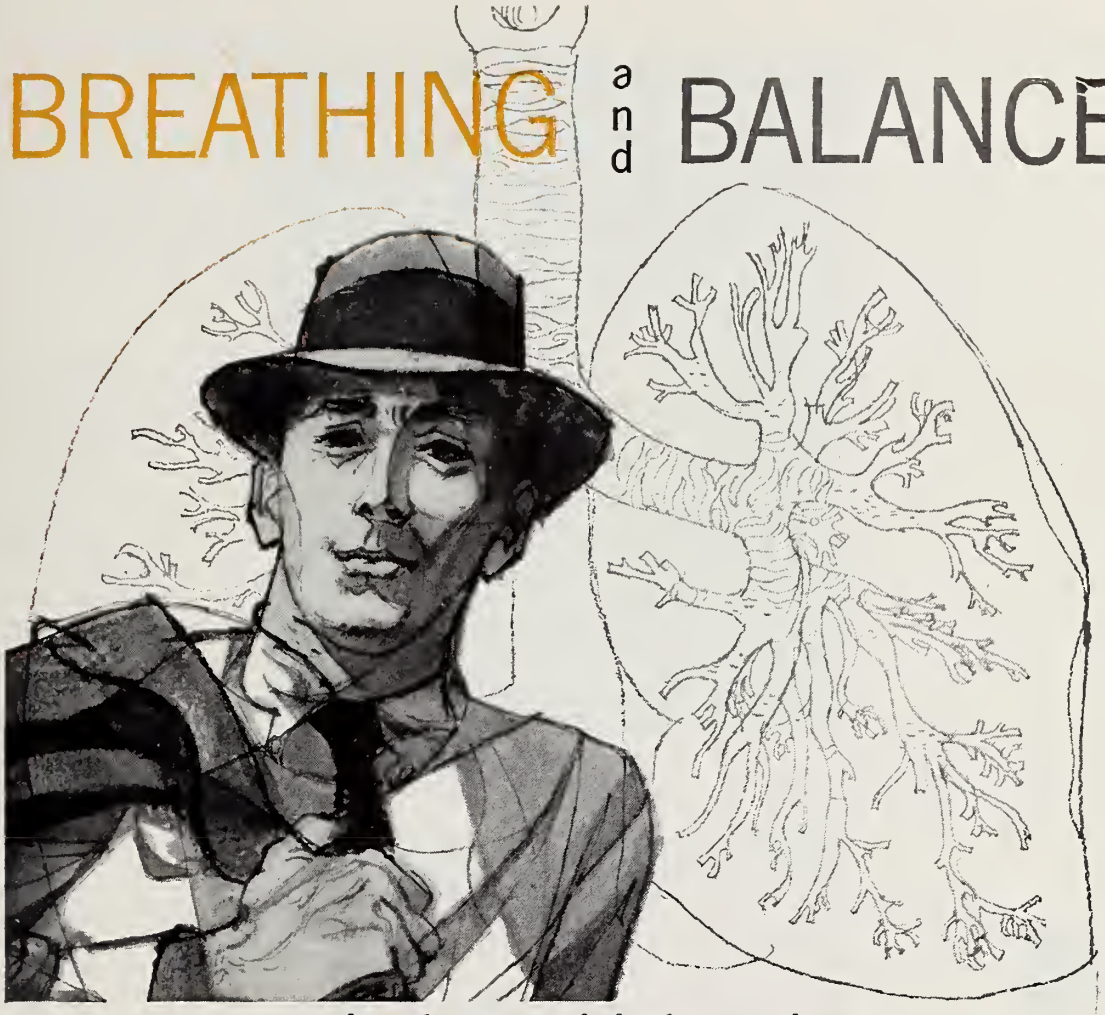
or by phone to arrive at more just decisions in particular cases which do not and cannot fit into the usual fee schedule. Outpatient work is not necessarily minor; a skilled surgeon may do more upon an outpatient, under local anesthetic, and without an assistant than an occasional surgeon in two or three hours upstairs, under general anesthetic, and with a retinue of bored attendants. Insurance carriers will find it poor economy to judge their fees by the number of stitches, type of anesthesia, assistant or not, number of square inches in a graft, length of time between stages in multiple-staged procedures, and number of days in the hospital. If they want to save some money there are better ways to do it than by short-changing claims of patients with real problems and by penalizing surgeons who shorten hospital stays, use more local anesthetics, work by themselves, and return the patient to duty at the earliest possible time. *Editorial. Realistic Adjudication of Surgical Fees. Rocky Mountain M.J. Aug.* 1956.

‹ ›

The clinico-pathological conference

This is a characteristically American educational medium and there are not many medical schools in this country or in countries other than the United States that employ it to advantage. Even when it is employed, the advantage to the student is not always obvious. It seems clear that attempts to enliven the clinico-pathological conference by shaping it artificially to a "who-dunnit" detective story certainly detract from its educational value. Conducted in a formal way, the clinical story being presented by a student, radiological and laboratory evidence being added, and clinical discussion being then followed by the pathological facts, the clinico-pathological conference can exercise a splendid integrating function on the student mind, demonstrating to him the unity of medical science, and the harmony of anatomy, physiology, medicine, surgery, and pathology in their several contributions to the doctor's understanding of his patient. This medium is one which could be used more generally with advantage in British medical schools. *Ian Aird, Ch.M. Techniques and Methods of Medical Education. Brit. M.J. Sept.* 1, 1956.

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*Schwartz, E.: New York J. Med. 56:570, 1956.

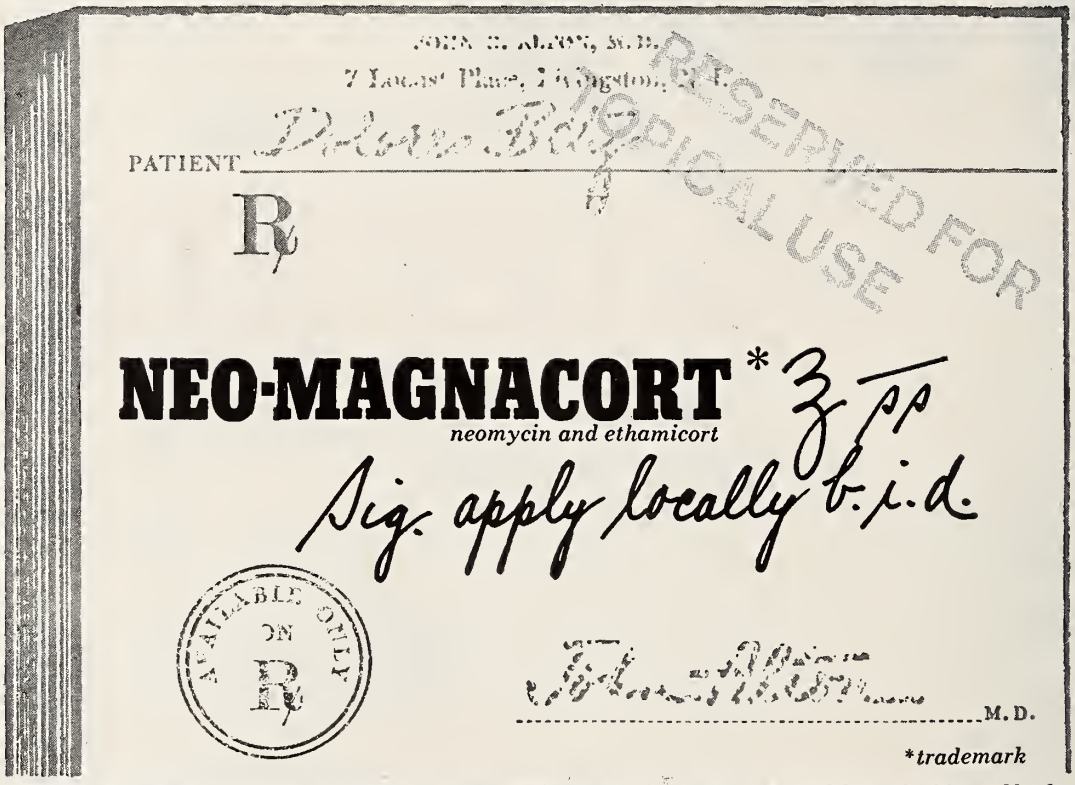
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Interstitial cystitis

This distressing conditions occurs mostly in women. It is characterized by frequent urination, day and night, usually associated with pain that manifests itself when the bladder begins to fill and disappears with voiding. The actual act of urination is not painful and if it is accompanied by burning, urethritis also is present. The urine from a patient with interstitial cystitis is free of pus and organisms. Diagnosis should be confirmed by cystoscopy. The treatment of choice in the severest forms of the condition has been overdistention of the bladder with the patient under anesthesia, followed by four to five days of continuous irrigation of the bladder with a solution of silver nitrate, starting with a 1 to 5,000 solution and increasing gradually until a 1 to 1,000 solution is being used. The patient is then dismissed from the hospital, and daily treatments with the 1 to 1,000 solution are continued in the office. If the condition has not been severe enough to require beginning the treatment in the hospital, the office management consists of the daily instillation of 1 ounce of silver nitrate solution beginning with a 1 to 5,000 strength. This concentration is increased daily until a 1 to 100 solution is instilled for two or three days. Interstitial cystitis has a great tendency to recur; if it does, subsequent courses of silver nitrate instillations may be necessary. Antibiotics and chemotherapy are of no value. *Edward N. Cook, M.D. Office Procedures in Urology. Misssissippi Valley M.J. July* 1956.

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Although acceptance of specific therapy is a primary goal in the control of tuberculous disease, it is not the only one. In a broader sense modern medicine strives to return to society an individual free from organic disease, capable of assuming personal, family, and community responsibilities. A concept such as this implies that the individual will be physically able to work — that he will have been prepared for some vocation. Not every patient, of course, will need to acquire a new occupation. There are many, however, who never have had a vocation and will have to be trained in one compatible with physical status and aptitude. Sidney H. Dressler, Am. Rev. Tuberc., August 1956.



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Tastiest way to dissolve sore throat symptoms

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(HYDROCORTISONE-BACITRACIN-TYROTHRICIN-NEOMYCIN-BENZOCAINE TROCHES)

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A prepared childbirth program

In substance, then, a Preparation for Childbirth Program is not a mysterious, difficult, or even a revolutionary technic of practicing obstetrics. The principles may be simply expressed as follows: We believe in the great intrinsic values of education for the mother, an understanding on her part of the process through which she is going. We believe that familiarity with the environment in which she expects to have her baby, acquaintance with and confidence in the personnel who expect to take care of her, and assurance that she will be cared for competently, sympathetically, and constantly will be factors of great help in the actual physical process of labor and delivery. We are fully aware of the fact that labor is painful; we believe that anybody who denies this is not facing reality. We are firmly of the belief that this pain should be controlled as much as possible, with the restrictions that its control result in no harm to the mother or the baby and that the mother retain an awareness of the progress of her labor and delivery as much as possible. We have no hesitation whatsoever in carrying out obstetric deliveries or appropriate episiotomy if it is in the best interests of the mother and infant. We believe that we think we have evidence to suggest that the equanimity and confidence with which the educated, prepared mother comes to the labor room, with ample support during labor, results in shorter, more efficient labors, more successful deliveries, and last but not least, a lowered maternal mortality. *C. Lee Buxton, M.D. An Evaluation of a Prepared Childbirth Program. New York J. Med. Sept.* 1, 1956.

‹ ›

Medicine and music are universally conceded to be international languages. Perhaps there are many more. The experience of the lawyers compares with our experience as physicians, in that it reveals an unquenchable determination among men of every land and language to assert the dignity of the individual, his inviolable rights to freedom of action, and the subordination of government to those rights. World Med. J., May, 1956.

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Cortisone for amenorrhea

Thirty-seven women between the ages of 17 and 39 years with amenorrhea or other menstrual disorder were treated with cortisone. Many of them were considered to have mild adrenogenitalism because of moderately raised urinary 17-ketosteroid excretion and mild to severe hirsutism. Others were thought to have a typical Stein-Leventhal syndrome; in these patients, enlarged ovaries were shown by X-ray or palpation. Thirty-two of the patients were married and 28 of these complained of sterility or relative infertility. The cortisone dose was adjusted to the level considered best for each patient and varied from 25 to 100 mg. of cortisone given orally daily. Most of the patients were given a daily dose of 50 mg. Later in the study, 20 mg. of hydrocortisone were given two or three times daily to some patients. In a few, treatment was started with an intramuscular injection of 100 mg. of cortisone or hydrocortisone, and in several, six to 10 pellets of 100 mg. each of cortisone were implanted; 32.4 mg. of thyroid extract daily were given routinely to counterbalance any hypothyroidism that might be produced by the cortisone, and 3.24 gm. of potassium chloride three times daily were added to compensate for excessive urinary excretion of the electrolyte. Patients were advised to remain on a high protein, low carbohydrate, low fat, low salt diet. Ten patients became pregnant during cortisone therapy or after therapy was discontinued. Five women had ovarian wedge resection because of failure to respond satisfactorily to cortisone therapy, and three of these conceived. There was a total of 15 pregnancies, four of which ended in abortion. Infertile women with amenorrhea, anovulatory menses, or other menstrual disorder, especially when these are complicated by varying degrees of hirsutism, should have the benefit of a three to six month trial course of cortisone before being subjected to wedge resection of the ovaries or irradiation therapy. An increased level of urinary 17-ketosteroids is a good but not a necessary indication for cortisone therapy. Of the 13 women who became pregnant, five had increased 17-ketosteroid levels, four had a borderline increase, and four

(*Continued on page 82*)

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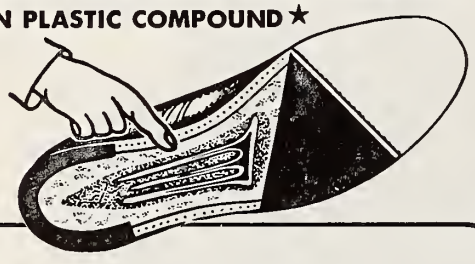
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had values within the normal limits of 7 to 13 mg. per 24 hours. As a rule, low-normal values of 11-oxycorticoids or 17-hydroxycorticoids were observed. Hirsutism is not a necessary prerequisite for cortisone therapy in patients with ovulatory disorders. *R. B. Greenblatt et al. Fertil. & Steril. May-June* 1956 *(as abstracted by J.A.M.A. Aug.* 4, 1956).

‹ ›

Lymph nodes, not glands

The terms "glands" or "lymph glands" also are currently misused as referring to lymph nodes. The old anatomy texts all employed the term "lymph glands" when lymph nodes were considered at the time as secretory organs. At the present time, however, their actual function is known and there no longer is any justification for calling them "glands" — a practice that leads to great confusion. For instance, when lymph nodes of the neck are called "glands of the neck" or "cervical glands" the less clear-thinking doctor is led erroneously to believe that metastasis takes place indiscriminately to various glandular structures, such as the parotid salivary gland, the submaxillary salivary gland, and the sublingual and thyroid glands. While it is true that such dissemination may occur, such terminology and belief lead to a misplaced emphasis and a failure to realize that an enlargement of lymph nodes actually is a most common form of dissemination. *Hayes Martin, M.D. Cancer Terminology. Cancer Bull. May-June* 1956.

‹ ›

Executive examinations

In the opinion of the examiners, 70 per cent of newly discovered disease warranted treatment. Where previously recognized disease was encountered, nearly half of the individuals could have benefited by additional treatment, while only slightly over 25 per cent were paying adequate attention to known disabilities. It is admittedly difficult to arrive at an accurate opinion concerning this latter question since frequently our information concerning the details of treatment was incomplete. The results suggest, however, since all of these individuals were at an economic level where good medical advice of it often was a matter of neglect. *Kendall A. Elsom, M.D. et al. An Appraisal of the Periodic Health Examination. Indust. Med. Aug.* 1956.

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‹ ›

The indispensable man

It has been said that there is no indispensable man but there is; the right man with the right idea at the right time in the pathway of history will ever be an indispensable man. *Editorial. The Uncommon Man. New York Med. July* 20, 1956 .

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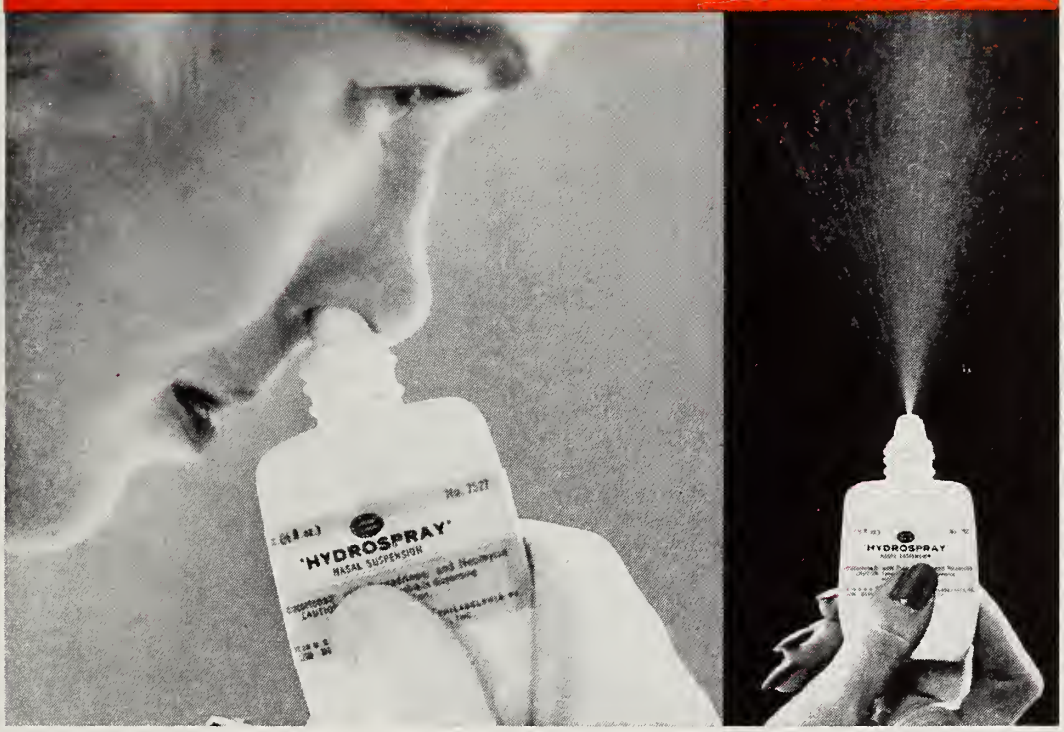
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Insane statistics

It is significant that the percentage of allergic individuals amongst the insane is far below the percentage of the normal population. *Harry S. Bernton, M.D. The Clinical and Biochemical Aspects of Allergy. Med. Ann. District of Columbia, July* 1956.

Laparotomy wounds

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The Month in Washington



Washington D.C. — The broad issue of federal construction grants for medical schools pending before the 85th Congress raises again a major question: To what extent is there a physician shortage in the United States?

The administration, through Secretary Folsom, maintains that the need for more doctors and research scientists is increasing rapidly as the population rises, as medical science grows more complex and as research programs are greatly expanded. And, he adds, the need undoubtedly will continue to increase in the years ahead.

Many of these schools already are in a critical financial plight, Mr. Folsom argues, and they need increased private and public funds "just to meet regular operating expenses." Under these circumstances, without further aid, "many schools face almost impossible obstacles in raising funds for construction of new classrooms, laboratories and other facilities." The Secretary then sounds this warning:

"Unless effective action is taken now toward providing these facilities, the shortage of medical scientists will grow much more acute in the years ahead, and the health of the American people will be retarded."

To solve this problem, the administration wants to broaden the program enacted last year for $30 million a year for three years to help build and equip laboratories doing research in various diseases. It asked the last Congress for $50 million a year for five years for both research labs and teaching facilities. The legislators only granted the $30-million-a-year part. That, says the administration, is not enough.

And to bolster that contention, Mr. Folsom cites the record on the lab facilities act: within three months after authorization, requests totalling well over $100 million were received by the Public Health Service.

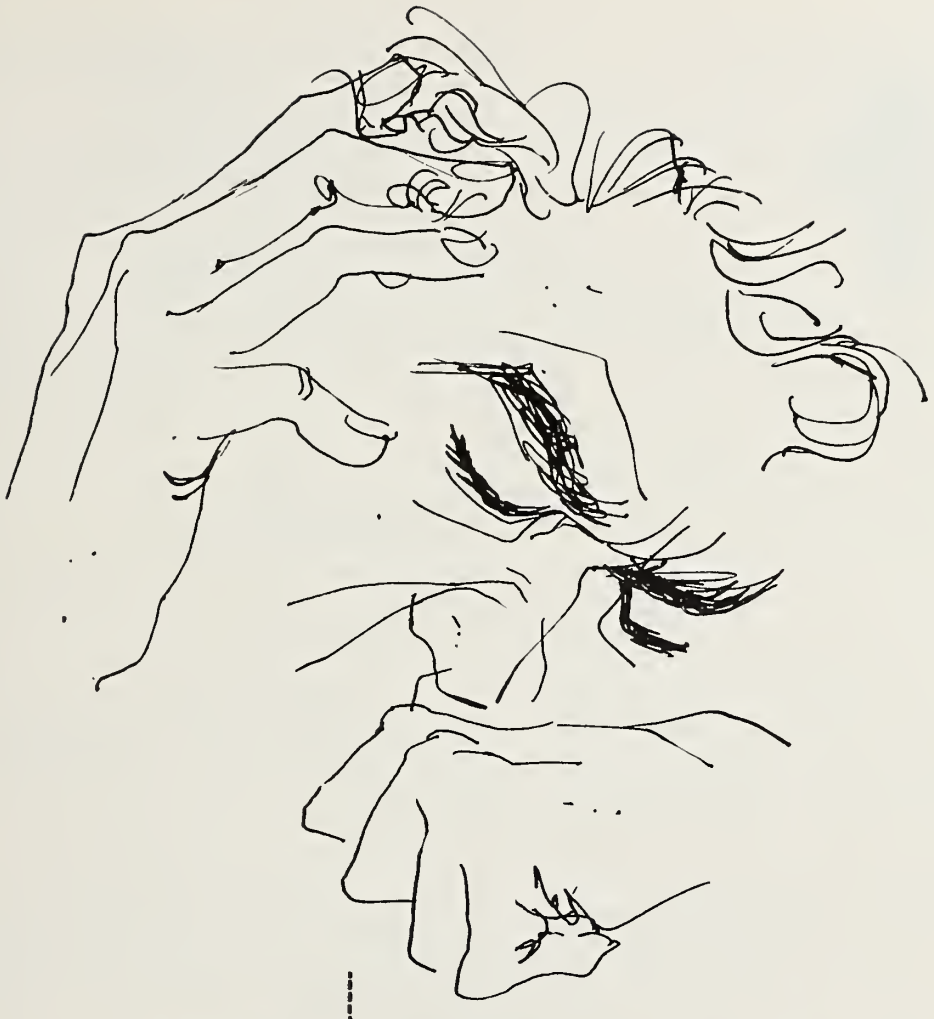
But when the committees of Congress — in all likelihood starting with the House Interstate and Foreign Commerce group — launch their hearings, members will want to know just how short the country is of doctors and whether reports of shortage take into account the increased productivity of each physician in the light of new techniques and other medical advances.

On the opening day of the 85th Congress, health legislation emerged as a popular subject. Of the approximately 2,000 bills, resolutions and private measures introduced that day, 70 were marked for study by the Washington Office of the American Medical Association. Experience has shown that about 3% of all measures are of medical importance.

Many of the bills were duplicates of those in the last Congress, while others were revised versions of old favorites. In the latter category were the Jenkins-Keogh bills (again bearing the numbers (H. R. 9 and H. R. 10) which would provide tax deferment on money paid in annuity plans, and the Bricker Amendment for keeping international treaties from affecting internal laws of the U.S.

The tax deferment proposal was changed in several respects, the most important being a provision for withdrawal of money from plans in advance of age 65, upon payment of a tax penalty. The key section in the proposed con-

(*Continued on page* 30)



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WASHINGTON (Continued)

stitutional amendment sponsored by the Ohio Senator states that "A provision of a treaty or other international agreement not made in pursuance of this Constitution shall have no force or effect."

One of the few surprises in the opening day rush to the bill hoppers was a bill by Rep. Poage (D., Tex.) to authorize the Secretary of HEW to make long-term, 3%-interest loans to nonprofit hospitals for construction and expansion of facilities, including nurses homes. Certain sectarian groups have been pressing for just such a plan in lieu of taking federal grant money under the Hill-Burton program.

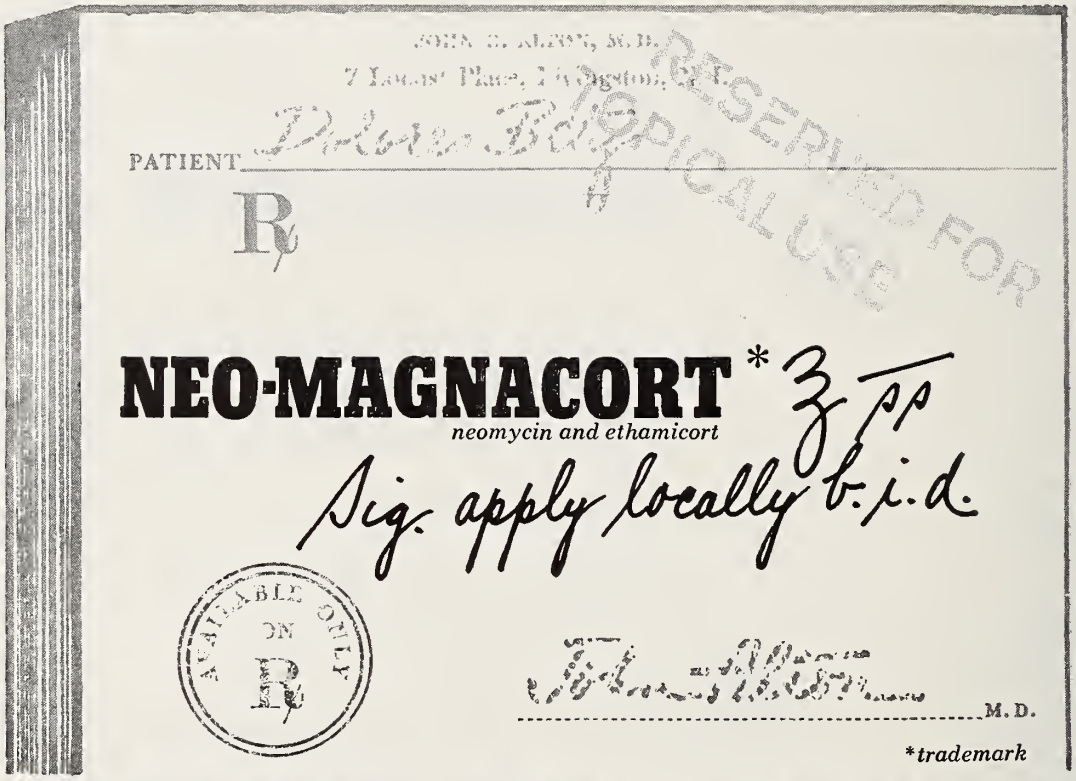
Moving to fill two major spots in the Department of HEW, President Eisenhower has named as Assistant Secretary 36-year-old Elliott L. Richardson, a Boston lawyer and son of the late Dr. Edward P. Richardson of Massachusetts General Hospital and Harvard Medical School. Mr. Richardson served at one time as law clerk to Judge Learned Hand and Justice Felix Frankfurter, as assistant to Senator Saltonstall and as consultant to former Gov. Christian Herter, now Under-Secretary of State.

To succeed Dr. Lowell T. Coggeshall as special assistant for health and medical affairs, the President appointed Dr. Aims C. McQuinness, a Philadelphia pediatrician who was last in Washington as a clinical consultant to the United Mine Workers Welfare and Retirement Fund. He was responsible for the medical staffing of the Fund's 10 memorial hospitals in three mining states. Dr. McGuinness was dean of the University of Pennsylvania Graduate School of Medicine and one-time director of Children's Hospital of Philadelphia.

Dr. Coggeshall, who returns to the University of Chicago, was praised by Mr. Folsom for his "splendid work on behalf of the health of the American people."

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It has never been possible to confine a disease such as tuberculosis to a narrow specialty. G. J. Wherrett, M.D., Canadian J. of Pub. H. Nov. 1956.



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The
ILLINOIS
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The Changing Outlook for Pemphigus

SAMUEL M. BLUEFARB, M.D. AND LEONARD HOIT, M.D., CHICAGO

THE prognosis of pemphigus appears to have been improved with the advent of steroid therapy. There was no effective treatment for this disease prior to cortisone and corticotropin and, although not curative, corticosteroids have proved to be the most effective and life prolonging therapeutic agents available.

Nelson and Brodey[1] reported 28 patients who were given steroid therapy for pemphigus for the period 1949 through 1954. Of these patients, 75 per cent were still living in 1954 and only two were seriously restricted in their activities, while one had maintained a clinical remission for 25 months without steroid therapy. The remainder were receiving the drug in varying dosages. Two patients died as a result of major thromboembolic accidents during treatment and the remaining seven who died probably received inadequate amounts of hormonal treatment, as judged by present standards. Nelson and Brodey also found that, aside from the thromboembolic episodes, the most serious side effects of long term corticosteroid therapy in these patients, were psychic disturbances, osteoporosis, and the reactivation of peptic ulcers.

Combes[2] described the results of 151 cases of pemphigus treated during 1945 to 1954. For the five year period to 1950 (when steroid therapy was begun) the death rate was 65 per cent in patients with pemphigus vulgaris and, with the use of hormones, mortality was reduced to 28.5 per cent. Of 15 cases of the foliaceous type in this series, only two died; among eight patients with the vegetans type, one died. Among 26 private patients, the death rate was 8 per cent, which Combes believes is due to the care exercised in administration of steroids and supportive therapy.

We have attempted to evaluate the general physical condition and mental outlook of patients having pemphigus of the vulgaris, vegetans, foliaceous, and erythematodes types. The cases are divided into three groups: the 1945-50 group includes patients treated prior to the use of steroid therapy; the 1951-54 group includes some patients who were given small amounts of corticotropin (ACTH); and the third group, for the period 1955 to date, consists of patients who received adequate corticotropin or cortisone therapy. Because of increased familiarity with the use of these steroids, the improved results were obtained during the last year. Our tabulations are shown in Table 1.

This tabulation reveals that 55.9 per cent of the patients in the first group (1945-50) died in the hospital while under treatment and 38.5

From the Department of Dermatology, Cook County Hospital, Samuel M. Bluefarb, M.D., Chairman, and the Department of Dermatology, Northwestern University Medical School, Herbert Rattner, M.D., Chairman.

TABLE 1.

TYPES OF PEMPHIGUS

Years	Sex	Race	Vulgaris	Vegetans	Foliaceous	Erythematodes	Total Cases	Died	Average Age: Years
1945-	M	N	2	0	0	0	2	2	61.5
1950	M	W	13	1	1	0	15	7	67.2
	F	N	4	0	0	0	4	1	59.5
	F	W	13	0	0	0	13	9	58.7
							34	19	
1951-	M	N	6	1	0	0	7	2	44
1954	M	W	7	0	1	0	8	3	61.5
	F	N	4	0	0	0	4	2	47
	F	W	11	0	0	1	12	3	64
							31	10	
1955-	M	N	3	0	0	0	3	1	41.3
	M	W	6	0	0	0	6	0	56
	F	N	0	0	0	0	0	0	—
	F	W	4	0	0	1	5	2	69
							14	3	

per cent in the second group (1950-54) died; an improved mortality rate of 17.4 per cent. By 1954, corticotropin and cortisone were readily available for the treatment of pemphigus. In that year, the mortality rate was 33.3 per cent for nine patients having pemphigus vulgaris. Among the three who died, one was an elderly woman who succumbed to a coronary occlusion. There were no cutaneous lesions at the time of her death and she had been receiving a maintenance dose of 100 mg. of cortisone daily. In the last group (1955-56), there were 15 patients, three of whom died. Therefore, the mortality rate decreased 11 per cent over the previous year and 41.6 per cent over the periods prior to steroid therapy.

At present, pemphigus patients are given an initial dose of 40 units of corticotropin gel twice daily and 100 mg. of cortisone, three times a day. In addition, the patient is given a low sodium diet, supplemental potassium, ascorbic acid, a multivitamin preparation, and diuretics and blood transfusions, when indicated. Antibiotics, which are changed every seven days, also are administered. This therapy usually is begun with penicillin, followed by tetracycline, sulfadiazine, erythromycin, and again, penicillin. In severe infections, the organism is cultured and its sensitivity determined. Patients having persistent open lesions or those requiring higher dosages of corticosteroid (250 mg. cortisone or 20 units ACTH gel) daily for maintenance therapy, also are given antibiotics or sulfadiazine.

The administration of corticotropin and cortisone is increased or decreased as required, and the corticotropin discontinued when the patient can be maintained on a daily dosage of 600 mg. or less of cortisone. The highest dosage administered in this series was 160 units of corticotropin gel and 1,000 mg. of cortisone, over a ten day period.

Laboratory studies, including serum sodium, potassium, and chloride determinations (by the flame photometer method) are done weekly on these patients. The fasting blood glucose is determined every two weeks and, more frequently, if the urinary sugar exceeds ¼ per cent (Clinitest). Roentgenograms of the lower spine and bony pelvis are made at least every six months. These examinations are performed on all hospitalized and out-patients who are receiving steriod therapy. Hospitalized patients usually are discharged for out-patient care when a daily maintenance dose of 150 mg. of cortisone or less is required, provided the patient is in good physical condition. Out-patients are instructed to maintain the low sodium diet and to continue the supplemental potassium (2 gm. potassium chloride). They also are requested to record their body weight weekly and to report immediately any gastrointestinal disturbance.

All out-patients are observed weekly or biweekly in a clinic devoted entirely to patients receiving steroid therapy. Attendance at this clinic is excellent; during the past three years only one patient failed to attend. There are probably several factors to account for this high

attendance rate: (1) the free provision of costly medications; (2) the careful general medical supervision of patients receiving steroid therapy (the advantage of early diagnosis of exacerbations, both as to prognosis and length of hospitalization, are explained to the patient); and (3) the necessity and purpose of frequent laboratory examinations is stressed.

Despite the high dosages of corticosteroids administered and the long periods of time involved, there were no instances of perforating gastric or duodenal ulcer or of pathological fracture in this series of cases.

Case 1: A 57 year old woman with pemphigus vulgaris, had developed numerous small bullae on the mouth, axillae, chest, and legs during the preceding three months. She had been given small doses of corticotropin for a period of two weeks but the bullous eruption became generalized and impetiginized and she was then hospitalized. She was given broad-spectrum antibiotics (tetracycline and clortetracycline) for three days and, when the infection was controlled, 40 units of corticotropin were administered intravenously each day. After the cutaneous lesions improved, corticotropin gel was given; the maximum dose being 120 units a day. After four months of therapy she was discharged from the hospital on a maintenance dose of 150 mg. of cortisone daily. Subsequently, two mild exacerbations of the disease occurred which were controlled by 300 mg. cortisone and 40 units corticotropin daily. All steroid therapy was discontinued after thirteen months and she has remained free of cutaneous lesions for more than two years.

Case 2: A 56 year old man had pemphigus vulgaris for eleven months prior to hospital admission at which time he presented a generalized bullous eruption. He was given 80 units of corticotropin gel daily and clortetracycline, 1 gm. daily. He developed a severe exacerbation of the disease six months later and his general physical condition deteriorated gradually despite the administration of 160 units of corticotropin gel and 250 mg. of cortisone daily. The corticotropin was then discontinued and the cortisone increased 100 mg. each day until he was receiving 900 mg. of cortisone daily. He improved steadily and after one year of therapy was discharged from the hospital, free of lesions, on a maintenance dose of 150 mg. of cortisone daily. This therapy was discontinued after ten months but the following month he developed a few small bullae on the scalp. There was rapid improvement with 40 units of corticotropin gel daily.

Case 3: A 36 year old Negro with pemphigus vulgaris had developed several bullae on the neck and in the mouth during the past three weeks. He did not improve on 300 mg. of cortisone daily but showed improvement with 80 units of corticotropin daily. He left the hospital after nine weeks, free of lesions. However, three weeks later he developed bullae in the mouth and on the neck and chest. Cortisone and corticotropin therapy was resumed. He was hospitalized for three months and continued on cortisone 150 mg. daily for the next four months. All therapy was then discontinued and he was free of lesions eight months later.

Case 4: A 62 year old man who had pemphigus vulgaris for several years was admitted with three quarter dollar sized bullae on the penis, leg, and conjunctivae. He had been receiving 20 units of corticotropin gel twice weekly. He showed rapid improvement with 300 mg. of cortisone daily and was discharged on a dosage of 150 mg. a day. This dose was reduced gradually and finally discontinued entirely. He has been free of lesions for the past five months.

Case 5: A 76 year old woman with pemphigus vulgaris had developed crops of bullae on the chest, trunk, and extremities, during the previous 18 months. On admission to the hospital she presented a generalized bullous eruption and was febrile and moribund. Treatment with 80 units daily of corticotropin gel and 1 gm. tetracycline daily resulted in some improvement of her general physical condition and the ability to ingest food. However, one month later she developed convulsions, lapsed into coma, and died within a few hours. Death was ascribed to "massive cerebral hemorrhage" although autopsy was not performed.

Case 6: This 30 year old Negro had large bullae involving the mouth, scalp, arms, chest, back, and abdomen. Following a diagnosis of pemphigus vulgaris, he was given a maximum dose of 120 units of corticotropin gel and 250 mg. of cortisone daily in addition to broad-spectrum antibiotics. He improved steadily and was discharged from the hospital, after five months, on a daily maintenance dose of 150 mg. cortisone. The following month he was readmitted with a severe exacerbation of the disease and was given a maximum dose of 120 units corticotropin gel and 500 mg. of cortisone daily. The course of the disease was erratic with several periods of improvement and several severe exacerbations. He showed improvement until one year later when he suddenly became demented, collapsed, lapsed into coma, and died the same day.

Case 7: A 70 year old woman with pemphigus vulgaris had diffuse and generalized bullous lesions. She responded favorably to intraveneous injections of 40 units corticotropin and intramuscular injections of 80 units corticotropin gel daily. She was discharged on a maintenance dose of 150 mg. cortisone but was readmitted eight months later with a mild exacerbation of the disease. She was then given a maximum dose of 80 units corticotropin gel and 300 mg. cortisone daily, which was decreased gradually until she received 150 mg. of cortisone daily. Meanwhile, she remained free of cutaneous lesions. Ten months later she was again hospitalized with a blood pressure of 110/60, pulse rate of 116, and respirations 40 per minute. The electrocardiogram was compatible with a coronary infarct and she died three days later.

Case 8: A 54 year old man first presented a crusted, infected lesion of the scalp which responded favorably to treatment with wet dressings and antibiotic ointments. There was scarring beneath these crusts. Two

weeks later he developed bullous lesions of the scalp, right eye, penis, and left leg. A diagnosis of pemphigus vulgaris was established and treatment consisting of a maximum daily dosage of 40 units of corticotropin gel and 250 mg. of cortisone were administered. He was discharged on cortisone therapy after two weeks of hospitalization and, 15 months later, he was receiving 25 mg. of cortisone daily, although he was free of lesions.

Case 9: This seriously ill, 43 year old man had a generalized bullous eruption. He had been hospitalized for 70 days in another institution where he had been given corticotropin and hydrocortisone therapy for pemphigus vulgaris. His initial treatment consisted of 40 units of corticotropin, administered intraveneously each day and large doses of tetracycline. The course of the disease was erratic and at one time he was receiving 160 units of corticotropin and 1,000 mg. of cortisone daily, for a period of 10 days. He responded slowly to therapy and was discharged six months later on a daily dose of 150 mg. of cortisone. Two weeks later he returned to work and has worked steadily since that time. At present he is receiving 75 mg. of cortisone daily and is free of cutaneous lesions.

Case 10: A 58 year old male with pemphigus vulgaris presented bullous lesions of the legs, chest, face and mouth which had been present for ten weeks. He responded well to initial treatment consisting of 80 units corticotropin gel and 300 mg. of cortisone daily. After eight weeks he was receiving only 150 mg. of cortisone daily but four days later he developed three small bullae on the ankle and the dosage was increased to 300 mg. a day. The dosage was gradually decreased and, one month later, he was again receiving 150 mg. of cortisone daily and was discharged ten days later on this dose.

Case 11: A 62 year old man with pemphigus vulgaris presented a generalized bullous eruption which had begun three months previously as a cutaneous eruption of the groin. Large bullae had been present on the body and in the mouth for two weeks. The cutaneous lesions responded favorably to intravenous injections of 40 units corticotropin and 300 mg. oral cortisone daily although several remissions occurred when the dosage was decreased. Cortisone subsequently was discontinued and he was given a maintenance dose of 40 mg. of prednisone daily. This dosage has been reduced to 20 mg. a day, which appears to be the minimum dosage required to control his disease.

Case 12: A 58 year old man having pemphigus vulgaris presented a bullous eruption involving the scalp, chest, abdomen, and mouth. He responded well to treatment with 80 units of corticotropin and 200 mg. of cortisone a day. This dosage was gradually decreased until he was receiving 100 mg. of cortisone daily and he was discharged two months later on this dosage. Six months later, a few small bullae developed in the pharyngeal mucosa and a crusted lesion on the forehead. This eruption was controlled with 200 mg. of cortisone daily. Today, 18 months later, the crusted lesion on the forehead is still present and the present dosage of cortisone is 50 mg. per day.

Case 13: A 65 year old woman presented an erythematous crusted eruption on the face, ears, sternal region, portions of the groin, and the sacral areas. There were several vesicles and small bullae. The cutaneous eruption did not respond to local therapy of an antibacterial and antiseborrheic nature. Following a diagnosis of pemphigus erythematodes, she was treated with corticotropin gel 80 units daily as well as hydrocortisone and antibiotic ointments locally. She responded well to therapy and was discharged two months later on a maintenance dose of 75 mg. of cortisone daily. This dosage was reduced to 25 mg. two months later and the following month only erythema of the center of the face and sternal region remained.

Case 14: A 77 year old woman was admitted with a moderately pruritic vesicular eruption of the arms and thighs. Histologic examination revealed a non-acantholytic bullae and a diagnosis of dermatitis herpetiformis was made. She did not respond to treatment with sulfapyridine and 60 units of corticotropin daily was then administered. She improved rapidly and was discharged the following month on a maintenance dose of 100 mg. of cortisone daily. However, two months later bullae had developed on the arms, legs, groin, and chest. Histological examination then revealed intra-epidermal bullae with acantholysis, and a diagnosis of pemphigus vulgaris was made. She responded favorably to treatment with corticotropin gel 80 units daily and cortisone 300 mg. daily, and was discharged four months later on a maintenance dose of 30 mg. of prednisone a day. Three months later she was receiving 15 mg. prednisone a day and is free of lesions.

SUMMARY

The outlook for patients with pemphigus is more favorable today than in the past. Statistics of patients having pemphigus of the vulgaris, foliaceous, vegetans, and erythematodes type, who were hospitalized during the period of 1945 to date, are presented. The increased survival rate of these patients since the introduction of corticotropin (ACTH) and cortisone therapy is discussed.

Case histories of patients who were given corticosteroid therapy, from 1954 to date, are summarized. These results appear to indicate that it is essential to administer corticosteroids over long periods to obtain the ultimate benefit from these drugs. The immediate improved outlook of these patients is excellent with this type of therapy.

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Treatment of Recurrent Cancer of the Cervix

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THE CERVIX is the most frequent site of malignancy in the female genital tract. Radiation therapy has been considered the method of choice in the initial treatment of the disease. In recurrence or persistence of the cancer a second or even a third course of radiation therapy has been employed in an attempt at control.

It is difficult to make a direct comparison between radiation therapy and surgical treatment of recurrent cancer of the cervix because the radiation therapist's evaluation of the disease is based upon a clinical impression prior to treatment whereas extent is based upon the microscopic finding of cancer in the surgical specimen. Reports in the literature dealing with cervical cancer deal largely with previously untreated cancer; and the results have been based on the League of Nations classification, which provides for only *untreated* cases.

In 1937, Meigs of Boston embarked upon a progam of panhysterectomy and pelvic lymphadenectomy for the treatment of selected cases of cervical cancer, including recurrent and untreated cases. The provision of a surgical specimen made possible an accurate evaluation by the pathologist of the extent of viable cancer in the pelvic lymph nodes. In a series of 231 cases of infiltrative cervical cancer cases reported by Meigs[1] it was found that in stage I (disease clinically confined to the cervix) 18 per cent had metastatic disease to pelvic lymph nodes; and of 109 cases in stage II (disease clinically confined to the cervix and upper vaginal canal) 40 per cent had metastatic disease to pelvic lymph nodes.

The use of ionizing radiation is designed to treat disease still confined to the accessible areas [cervix and upper vaginal canal]. Extension of cancer into pelvic lymph nodes beyond the paracervical and paravaginal areas cannot be sterilized by the present methods of radiation treatment.

Late radiation effects upon the urinary tract were reported by Everett, et al.[2], following a well planned and executed course of ionizing radiation for cervical cancer. They were able to study 33 patients in whom pre- and post-treatment urological tract studies had been carried out. Of the 33 patients studied, 16 [48.4 per cent] showed some evidence of ureteral obstruction; and 18 [54.5 per cent] showed some type of bladder lesion. In only about 15 per cent were the ureteral obstructions sufficiently severe to be of clinical importance; and in only about 20 per cent were the bladder lesions of serious clinical significance.

A classification for cervical cancer cases treated surgically was proposed by Meigs and Brunschwig[3] in 1952. This classification is based upon the pathologist's findings of cancer in the surgical specimen. Adenocarcinoma of the cervix and "stump" cancer are provided for in this classification. There is no provision for noninfiltrative cancer, which was intentionally excluded. The classification, in brief, is:

Class A—Cancer confined to the cervix.

Class B—Cancer extends into the lower uterine segment and/or upper third of vagina.

Class C—Cancer extends into parametrial tissue and/or metastasis to parametrial lymph nodes and/or ovaries.

Class D—Metastasis to hypogastric and/or obturator and/or external iliac lymph nodes.

Class E—Extension of cancer into bladder and/or rectum, with or without lymph node metastasis.

It has long been recognized that in most persons dying of uncontrolled cervical cancer, the disease was still confined to the pelvis. This has been substantiated by the study of autopsy material in both treated and untreated cases.

Metastasis from the cervix in cases of squamous cancer follows a fairly uniform pattern of distribution in the pelvic lymph nodes before extending outside the pelvis. The earliest site of lymph node metastasis is to the paracervical and paravaginal lymph nodes, followed by the

obturator nodes and the hypogastric chain of lymphatics. Henrickson[4], in a careful necropsy study of 41 patients with carcinoma of the cervix, feels that nodes in the first echelon (the "primary" group) usually are involved before metastasis extends to the secondary group. The successful surgical approach to this problem of recurrent cervix cancer is predicated upon this pattern of distribution.

It is worthy of note that three cases in Henrickson's series, in clinical stage I, died of uremia secondary to ureteral obstruction, the longest survivor living 24 months after the completion of radiation therapy. These three cases are mentioned to point out that they were still amenable to "cure" by hysterectomy and pelvic lymphadenectomy, with diversion of the urinary tract.

In a review of 169 necropsies of treated cervix cancer reported by Rojas and Meigs[5], cancer was still confined to the pelvis in 77.6 per cent. Their tabulation of causes of death showed that ureteral obstruction and uremia occurred in 78 of the 169 cases [46.1 per cent]; and that perforation and peritonitis occurred in 38 cases [22.4] per cent. Fistulas were present in 89 of the 169 cases [52 per cent]. Many of the fistulas were due to radiation necrosis and some, to cancer. This series demonstrated the futility of reirradiation for recurrent disease. It also shows the natural history of radiation treated but uncontrolled cervical cancer, of which 77.6 per cent of the cases studied remained confined to the pelvis.

Cases of cervical cancer which had recurred after either previous radiation or previous surgery "in an attempt to cure," with survival from 4 years to 5 years and 10 months, were reported by Brunschwig.[6] The recurrent cases were tabulated from his report based on the surgical classification. Untreated, or "fresh," cases were excluded as were those in which viable cancer, although demonstrated by biopsy prior to surgery, was not found in the surgical specimen. It is of interest to note that although no viable cancer was demonstrated in the nine cases where recurrence was limited to the cervix, two of these patients [2/9ths or 22 per cent) died of the disease despite the absence of demonstrable tumor in the specimen submitted to the pathologist.

Recurrent Cervical Cancer

	Number	Living	Died	
Class RA	9	5	4	
SRA	3	3	0	
Total	12	8	4	— 8/12 or 66%
Class RA_o	8	6	2	
SRA_o	1	1	0	
Total	9	7	2	— 7/9 or 78%
Class RB	6	2	4	— 2/6 or 33%
Class RC	5	0	5	
SRC	1	1	0	
Total	6	1	5	— 1/6 or 16.6%
Class RD	3	1	2	
SRD	1	0	1	
Total	4	1	3	— 1/4 or 25%
Class RE	28	6	22	
SRE	6	1	5	
SE	2	1	1	
Total	36	8	28	— 8/36 or 22%
	Total (Excluding A_o cases)			
Class A	12	8	4	— 8/12 or 66%
B	6	2	4	— 2/6 or 33%
C	6	1	5	— 1/6 or 16.6%
Total	12	8	4	
D	4	1	3	— 1/4 or 25%
E	36	8	28	— 8/36 or 22%
TOTAL	64	20	44	—20/64 or 33%

Prefixes:
R—previous radiation in an attempt to "cure"
S—previous surgery in an attempt to "cure"
$_o$—indicates cancer was present in the cervix by biopsy, but not found in the surgical specimen, e.g., A_o

Class E constituted more than half the total of all recurrent cases. These required either partial or total pelvic exenteration. The surgical mortality (defined as death within 30 days of operation) for 21 cases requiring anterior partial exenteration and 40 cases requiring total

pelvic exenteration, a total of 61 exenterations, with 15 deaths, was 25 per cent. Eight, or 22 per cent of the group, are without evidence of disease from 4 years to 5 years and 10 months after surgery.

	Number	Surgical Mortality
Anterior Partial Pelvic Exenteration	21	5
Total Pelvic Exenteration	40	10
Total	61	15—15/61 or 25%

If the disease does not require either partial or total pelvic exenteration, the operative mortality is no higher than that for panhysterectomy without pelvic lymph node dissection. In a group of 157 cases treated by panhysterectomy and pelvic lymphadenectomy, there was one death, or an operative mortality of .63 per cent. Panhysterectomy with pelvic lymphadenectomy carries an eight to 10 per cent incidence of complications, chiefly of the urinary tract. Ureteral fistulas account for the majority of the complications; the rest are the result of bladder dysfunction extending beyond the period of hospitalization. Bladder dysfunction is consistent with the lymphadenectomy and deperitonealization of the pelvis and is temporary.

OPERATIVE PROCEDURE

The preoperative preparation of the patient with recurrent cervical cancer includes evaluation of the urinary tract by pylography and cystoscopy. Cystoscopy may be omitted if there is no possibility of bladder involvement by either tumor or radiation damage. Bowel preparation consists of mechanical cleansing of the lower bowel by catharsis for three days prior to surgery. The use of antibiotics has been found to be less effective than mechanical emptying.

Preoperative hematic studies and base-line chemistries are obtained. Blood volume studies may be indicated; and if so, the blood replacement is carried out prior to surgery, correcting the red cell mass deficit within 200 cc. of the patient's calculated ideal red cell mass. The method of calculating[7] the so-called normal when there are obesity or weight loss correction factors to compute may not be absolute, but it is practical. It has been our experience that if a patient's red cell mass is within 200 cc. of his calculated ideal, his blood replacement has been adequate. Six pints of blood are made available on the morning of operation.

The anaesthetic agents used, unless contraindicated, are Pentothal sodium® and gas-oxygen-ether. An endotracheal tube is passed at the time of induction. Curare-like drugs are used to obtain relaxation at the time of exploration and closure.

After entering the abdominal cavity and ascertaining by palpation and visual inspection that the disease does not extend above the pelvic brim, one proceeds with pelvic lymphadenectomy and hysterectomy. Complete deperitonealization of the pelvis will be included with the pelvic lymph node dissection below the pelvic brim. A narrow portion of parietal peritoneum is preserved and left attached to the ureters as they are dissected down to the infundibular portion of the bladder. The preservation of the blood supply when "stripping" the ureters is of paramount importance. This, however, is not done at the expense of leaving disease behind. Only after identifying and freeing the ureters from the level of bifurcation of the common iliac vessels to the bladder should one proceed with the lymph node dissection.

The external iliac chain of nodes, with their surrounding fatty and areolar tissue, are removed from the femoral canal distally, to the bifurcation of the common iliacs, proximally. The hypogastric lymphatic chain is removed, as well as the nodes and tissue below the bifurcation of the aorta and overlying the inferior vena cava. As the dissection is carried deeper into the pelvis, the obturator nerves are identified and stripped of their surrounding fatty and areolar tissues along their course and in the obturator fossae. The supralevator fascia is wiped clean of its overlying areolar tissue and is swept medially toward the uterus and vagina. The vaginal cuff is developed both anteriorly and posteriorly. The round ligaments are cut at their point of entrance into the canal of Nuck, the infundibulopelvic ligaments and their vascular contents are isolated and divided at the pelvic brim, and the uterosacral ligaments are divided at their point of origin. The vaginal cuff is divided well below the area of disease, to permit an adequate margin of resection. The entire specimen, with the lymphatic dissection, is then removed.

At the time of trimming the base of the blad-

der, prior to freeing the bladder from the vagina, there will be bleeding which will continue until the specimen is removed and the pelvis is tightly packed with laparotomy pads. Injury to the ureters must be avoided at this time.

The bleeding points are controlled with ligatures; but oozing from the deperitonealized pelvis will persist. The upper cut end of the vagina is left open, and a running hemostatic suture is used to control the bleeding from the vaginal cuff. Two pelvic rolls are placed carefully and firmly into the denuded pelvis, the distal ends of the packs having first been placed into the open vaginal canal. The ureters are lying free above the pelvic rolls.

Blood loss during surgery is estimated by measuring the volume of blood collected in the suction bottle and by weighing the used laparotomy pads. During the operation blood is replaced as the loss occurs. A Foley catheter is left in the bladder postoperatively, and the patient is placed on straight bottle drainage. A retention catheter is left in the bladder until the urinary residual is 100 cc. or less.

The pelvic packs are removed on the second postoperative day, under intravenous Pentothal sodium. Correction of any blood deficit is carried out in the postoperative period. The period of hospitalization is about twelve to fourteen days. Bladder dysfunction would not necessarily require prolonged hospitalization. Antibiotics and urinary tract antiseptics are used in the postoperative period.

Partial or total pelvic exenteration will not be considered at this time.

COMMENTS

The surgical program for treatment of recurrent cervical cancer cases has been reviewed, and the value of the classification of all infiltrative cervix cancer cases, based upon the pathologist's findings of cancer in the surgical specimen, has been emphasized.

The studies of autopsy material from patients dying with uncontrolled cervical cancer have shown that in a high percentage of these cases, the disease was confined within the pelvis. A well documented urological study of patients treated with ionizing radiation showed significant damage in 15 to 20 per cent of the cases studied. A study of 64 cases of recurrent cervical cancer followed from four years to five years and ten months, treated by a surgical program, yielded 20/64 [33 per cent] free of disease. The surgical morbidity of recurrent cervix cancer is 8 to 10 per cent and results primarily from urinary tract complications.

The surgical program has been described briefly. It has been this author's desire not to minimize the magnitude of the operation, despite the low operative mortality (0.63 per cent) in cases requiring only hysterectomy and pelvic node dissection. He also wishes to call attention to the salvage of eight out of 36 patients [22 per cent] of those requiring partial anterior or total pelvic exenteration, notwithstanding the 25 per cent operative mortality in a series of 61 cases.

CONCLUSIONS

1. Recurrent cervical cancer is not amenable to further radiation therapy.
2. Cervical cancer remained confined to the pelvis and pelvic lymph nodes in 78 per cent of patients dying of uncontrolled cancer of the cervix.
3. Panhysterectomy and pelvic lymphadenectomy can offer a chance of "cure" in cases in which the disease has remained confined to the pelvis.
4. Urinary bladder dysfunction and ureteral fistulas account for the major morbidity of panhysterectomy combined with pelvic lymphadenectomy.
5. The over-all "cure rate" of 64 recurrent cervical cancer cases treated by a surgical program and followed from four years to five years and ten months is 20/64, or 33 per cent.

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Alseroxylon (Rauwiloid) Therapy in Disturbed Elderly Patients

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THE management of disturbed elderly patients has always presented a problem. Barbiturates and other sedative drugs have been used widely, but the clinical response has not been satisfactory.

Although rauwolfia serpentina had long been utilized as a tranquilizing drug in India, it was introduced originally in this country as a hypotensive agent. As the drug became more widely used, it became apparent that rauwolfia was a valuable tranquilizing and mildly bradycrotic as well as a mildly hypotensive agent. In addition, it is remarkably free from toxicity.

An extract of rauwolfia serpentina (alseroxylon fraction - Rauwiloid®) has been used on 23 elderly, disturbed, and difficult to manage domiciliary patients. The results have been sufficiently good to warrant publication of this report. The study is continuing.

METHODS AND MATERIALS

Of the 23 patients in this study there were six males and 17 females. The age range was 40-90 years, 19 of whom ranged from 75-90. All were domiciliary patients, living in two convalescent homes. The average duration of therapy was six months, ranging from one month in 1 case to one year in another. The majority of the patients have been treated for five to 8 months. The average dose of Rauwiloil was 12 mg. daily (4 mg. three times daily). This was the only therapy in 22 of the 23 patients. One patient received Rauwiloid-Veriloid, 1 tablet three times daily, because of severe hypertension.

RESULTS

Clinical results were excellent in four patients, good in 10, and fair in five. Four were unimproved. A response rate of good to excellent in 14 of the 23 patients is deemed satisfactory for this difficult type of patient. That only four of the 23 patients failed to manifest any significant improvement attests the value of Rauwiloid therapy in such patients.

One patient (senile dementia) did not respond to Rauwiloid initially, but improved on chlorpromazine. After 8 weeks, she was changed back to Rauwiloid, and clinical improvement was maintained. Two patients did not show any significant response to Rauwiloid; they also were refractory to all other therapeutic measures, including chlorpromazine. One depressed patient showed no response to 5 months of therapy. However, one patient with C.V.A. and depression showed a good response which continued over 10 months; another patient (parkinsonian) with depression was also improved, and this improvement has lasted for over 5 months. We are aware that depression constitutes a relative contraindication to rauwolfia therapy, but the depression was not aggravated by the therapy in any case, even over such long period.

A significant hypotensive response was seen in 10 patients, a milder response in an additional three patients. In 10 patients the blood pressure remained unchanged. There was no extreme reduction in blood pressure. The greatest reduction seen was from 230/130 to 170/70, achieved over a 5 month period.

A distinct bradycrotic effect was seen in seven of 20 patients, and a milder bradycrotic effect in two additional patients. In 11 of 20 patients there was no significant effect on pulse rate. The bradycrotic action was welcome. There was no excessive bradycardia. The greatest reduction in pulse rate was from 110 to 90, over a 5 month period. The lowest pulse rate noted was 72. In no instance was a tachycardiac effect noted.

DISCUSSION

Many investigators have commented favorably on the value of rauwolfia as a tranquilizing agent for elderly patients. Lipsett, et al.[1] used Rauwiloid in a group of domiciliary hypertensive patients, and reported that while objective improvement was seen in all cases, subjective improvement was even more striking. Sainz[2] reported that geriatric patients became less irri-

P.	Age	Diagnosis	BP Control	BP After Therapy	Pulse Rate Control	Pulse Rate After Therapy	Therapy	Results	Impression of Therapy
SB F	90	Senile Dementia	200/90	150/90	100	90	Rauwiloid 12 mg. daily	Easier to manage Quieter Still confused	Improved
SM M	85	Senile Dementia	160/70	160/70	80	80	Rauwiloid 8 mg. daily	More manageable Fewer outbursts Quieter	Considerable improvement
LB F	76	C.V.A. and depression	210/100	200/95	88	80	Rauwiloid † Veriloid 1 tab t.i.d.	Improved mental attitude Less depressed	Improved
FP F	73	C.V.A. Hypertension	185/60	145/65	100	90	Rauwiloid 12 mg. daily	Patient cheerful co-operative. Blood pressure lower	Good improvement
SE F	80	C.V.A. Diabetes mellitus	180/100	140/90	96	80	Rauwiloid 12 mg. daily	More alert, cheerful BP lowered	Improved
S. F	76	Senile dementia Multiple "Little strokes"	180/100	180/90	100	100	Rauwiloid 12 mg. daily	Co-operative, cheerful, but still confused and childish	Improved
TB F	74	Hypertension Diabetes Fibrillation Nervous	230/100	170/70	110	90	Rauwiloid 12 mg. daily	Blood pressure reduced, nervousness reduced	Good improvement
GG F	88	Senile dementia, hypertension	180/90	180/90	88	88	Rauwiloid 12 mg. daily	No significant effect in 1 month	No improvement
JL M	72	Cerebral arterio-sclerosis	180/80	180/80	88	88	Rauwiloid 12 mg. daily	No significant improvement	No improvement
IC M	78	Hemiplegia Tenseness Hiccup	180/90	160/80	76	76	Rauwiloid 12 mg. daily	Good reduction in blood pressure, less tense, hiccup unchanged	Improved
ET F	79	Hemiplegia Hypertension Restlessness	210/120	160/80	76	76	Rauwiloid 12 mg. daily	Good improvement, BP reduced, less restless, sleeps better	Considerable improvement
HS F	70	Mental depression, attempted suicide	135/76	135/76	80	80	Rauwiloid 12 mg. daily	No significant change	No improvement
SC	74 F	Hypertension Senility	180/110	150/90	76	76	Rauwiloid 12 mg. daily	Disposition better, BP reduced	Good improvement
LL F	79	Senile dementia Diabetes	170/100	150/90	80	80	Rauwiloid 12 mg. daily	Less nervous, still confused BP reduced	Improved
RL F	80	Senility Blindness	140/90	140/90	72	72	Rauwiloid 12 mg. daily	Patient quieter, more manageable	Good improvement
BM F	80	Senility	150/100	150/100	76	72	Rauwiloid 12 mg. daily	More congenial, less demanding, more manageable	Good improvement
MR M	79	Hemiparesis Hypertension Amputee	200/120	180/100	72	70	Rauwiloid 12 mg daily	Less irritable BP reduced	Good improvement
W. F	65	Manic-noisy	140/90	140/90	72	70	Rauwiloid 12 mg. daily	Personality improved, less noisy	Improved
McA F	58	Depression Irritability	144/90	144/90	80	80	Rauwiloid 12 mg. daily	Good improvement, but this did not persist	Improved
RR M	60	Parkinson's disease Paranoia	130/80	130/80	80	80	Rauwiloid 12 mg. daily	Good mental improvement	Considerable improvement
GL F	40	Hypertension Rheumatic heart disease	180/100	150/90	88	80	Rauwiloid 12 mg. daily	No significant improvement	No improvement
RA M		Hypertension Nervous tension	180/100	130/80	88	88	Rauwiloid 12 mg. daily	Significant lessening of tension	Considerable improvement
K. F	75	Manic depressive (Depressive stage)	210/110	180/100	100	100	Rauwiloid 12 mg. daily	Mental status greatly improved	Considerable improvement

table, agitated, and quarrelsome on reserpine therapy, and there was improvement in fearfulness and anxiety. Freis[3] has described rauwolfia derivatives as the easiest of all hypotensive agents to administer to elderly patients. Harris and Phelan[4] have emphasized the value of rauwolfia derivatives for tranquilizing disturbing emotions of elderly patients. Many similar reports could be cited.

We selected the alseroxylon fraction of rauwolfia (Rauwiloid) for use in our patients since, in our experience, the tranquilizing, bradycrotic, and hypotensive actions were similar to those obtainable with reserpine; but the dosage was not as critical and side actions were not as troublesome. This has been reported also by other investigators.

We saw no ill effects that could be ascribed to the therapy. Side actions to the therapy were either completely absent or so mild as to be inconsequential.

The clinical response to Rauwiloid is rather slow in onset and develops gradually. This is a distinct advantage. As the effect persists for several days after withdrawal of the drug, it is safe to stop the compound at any time with no danger of sudden rebound of the blood pressure.

Our overall impression is that Rauwiloid alone quiets the moderately disturbed, tense, apprehensive, worrisome, and difficult to manage patient. In the more severely disturbed and excitable patient, it may be necessary to add chlorpromazine, particularly at the beginning of treatment. After the patient has been quieted, Rauwiloid alone usually is adequate to maintain the improvement.

Its remarkable freedom from toxicity makes Rauwiloid the first choice of therapy for these patients. The tranquilizing and mildly bradycrotic action plus the mild antihypertensive effect produces a desirable change in these patients. They become quieter, more cheerful, and less tense and apprehensive. Thus management of the previously difficult to manage patients is simplified greatly.

SUMMARY AND CONCLUSIONS

I. Alseroxylon (Rauwiloid) has been used on 23 elderly, disturbed, and difficult to manage domiciliary patients.

II. Clinical results were excellent in 4, good in 10, fair in 5, and poor in 4 patients.

III. Side actions to the therapy were negligible.

IV. Over 80% of the patients were improved to the extent that management was simplified greatly.

V. Rauwiloid alone provides adequate therapy for moderately disturbed, apprehensive, and worrisome patients. In the more severely disturbed and excitable patient, chlorpromazine was effective in calming the patient, the improvement later being maintained by Rauwiloid alone.

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Cause of suffering

In Buddist thought, desire and attachment are considered to be the cause of suffering. Those of us in the western tradition might modify this stern, totalitarian opinion and allow that desire for and attachment to higher values and ideals are not only permissible but necessary, even at the cost of suffering. We can agree that exclusive and excessive worldly desires and attachments are potent sources of misery. Again, it seems to be fundamentally a matter of fear — fear that we shall not obtain what we desire; that we shall lose what we have; that we shall obtain what we do not desire. With the exception of purely materialistic knowledge and thinking, the thoughts of man, in many times and places, create a garment of numerous threads wherewith to clothe himself from the cold currents of the existential predicament; or the problem of existence as such. *H. M. Flanagan. The Anxious Patient. Lancet, Aug.* 4, 1956.

Respiration in School Children Recoverable Hearing and Nasal

E. M. Herzon, M.D., Elgin

A recent survey by the National Education Association listed 30,179,357 pupils in public elementary and high schools[1]. Another report[2] says about 10% of school age children have a significant hearing deficiency as determined through audiometric screening tests. This paper has reference to these 3,000,000 children. The U. S. Public Health Service[2] made an estimate of only 18,000 school age children in the United States with sufficient hearing impairment to warrant the term "deaf." What of the multitudes with hearing loss not sufficient to be called deafness?

This report of 350 cases encountered in private practice deals with the problem at the grass roots level. It must be understood that otolaryngologists care for but a few per cent of these millions of children. All cases in this survey were 4 years of age and up. They all had acquired verbal communication or speech and no "deaf" children were included. One qualification adopted in selecting cases was that there be no obvious cause for the hearing loss found on the audiometer test of each child. Automatically, children with acute upper respiratory infections were not included. Cases with acute or chronic otitis media or otitis externa, cerumen blockage, serous otitis, tympanic membrane perforations, or marked distortions of the drum were likewise excluded because of the obvious relationship to hearing loss. The author hoped to zero-in on a new conception of hearing losses in school children in its true magnitude by an analysis of the management and end results of treatment in this series.

HISTORY AND SYMPTOMS

The patients were seemingly in good health yet there was a suspicion by the parents or teacher that hearing should be checked. Some of the complaints of the mother were that the child did not appear to hear her calls, was inattentive to noises around the house, or turned television on very loud. Some considered the child a behavior problem in not minding the parents and doing things they were told not to do. Parents often were chagrined because their child, who had always been perfectly normal to them in every respect, was found to have an audiometric deficiency.[3]

In half of these 350 cases neither parent nor child was aware of any hearing loss. In many cases the school examination corroborated the suspicions of the parents, and so the child was brought in.

In the analysis of symptoms, hearing loss was present in 40% of the cases, otalgia in 33%, and mouth breathing in 30%. In 19% there were no complaints. Snoring, nasal blocking, nasal discharge, anorexia, cough, epistaxis, and sore throats occurred in few instances.

PATHOGENESIS

Before going into a description of the physical findings of these cases, it is necessary to comprehend the basic physiological principles at work in hearing losses of children. All the following factors play their role dynamically in the etiology of this entity. It is upon the recognition of all these factors, acting proportionately in each individual, that a hearing loss becomes manifest or that it disappears by the automatic corrective forces of the body.

1. Lymphatic drainage of the first branchial pouch derivatives.
2. Conception of allergy in its broadest sense.
3. Bacterial and viral infection of the upper respiratory system.
4. Physiological functioning of the nose and nasal passages including eustachian tubes in respiration.

Understanding recoverable hearing loss means knowing the lymphatic anatomy of the derivatives of the first branchial pouch and what happens when pathological stimuli are applied to the lymphatic structures draining this area of the body.[4,5] Lymph flows from the middle ear

to the eustachian tube and is continuous with the pre-eustachian plexus draining the rest of the first branchial pouch derivatives such as the lining of the nose, sinuses, and nasopharynx. Then it goes into the retropharyngeal nodes. Lymph also flows via an accessory transtympanic path to the parotid and deep cervical nodes. Retrograde flow occurs often, so that pathology of the nose, as in upper respiratory infections, is commonly responsible for tubal catarrah and conduction middle ear deafness.[5]

PHYSICAL EXAMINATION

In the light of this lymphatic pattern, the physical findings may be seen in their proper perspective. First, in respect to the ear, the tympanic membrane appears intact. However, upon close scrutiny, there may or may not be found retraction of the drum and prominence of the short process of the malleus. The color of the drum is off in many cases, ranging from lack of translucency to opacity, from gray to yellowish cast (all signs of passive congestion originating from the eustachian tube lymphatic plexus). Next, the test of function by tubal inflation may or may not improve hearing. In fact, I have minimized this diagnostic test because lack of improvement of hearing does not mean that middle ear passive congestion does not exist. It merely means that the tube is still patent but there may be middle ear passive congestion which can account for the hearing loss, which may even resemble the perceptive type on the audiogram.

The physical findings of the nose are a remarkable commentary on the popular lay conception of normal health in this modern era. Children's noses may commonly be seen with excoriated nostrils, passages full of mucus and pus, and redness of the soft tissues at the nasal orifices, resulting from local allergic sensitization of tissues from long standing nasal secretions. Yet upon interrogation of parents, there are no nasal complaints and "no obvious cause" is present for the hearing loss. This situation is accepted as normal by many people today or parents think the child is having another cold. Indeed, these signs lasting for weeks, months and even years, are expected to be outgrown.

Functional Nasal Respiratory Test: The nasal passages show varying degrees of obstruction with nasal respiratory decompensation (Figure 1.) When looking into the normal nasal

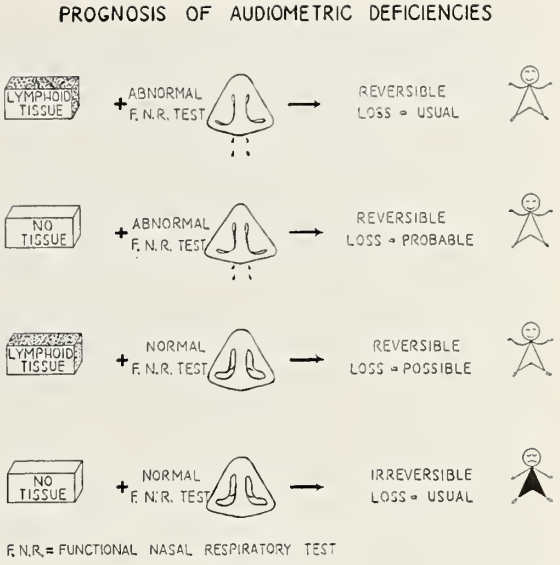


Figure 1

passages with a head mirror, usually only the vestibule is seen, ending in a blind vertical narrow slit, opening into the inferior meatus, about 1 mm. in width. The air passing through the nose in a thin laminar flow, sheetlike, past the choanae, is the normal functional position or normal laminar flow position. Often in pathological states and occasionally, in the warmer months of the year or after a person has been in a warmed room for awhile, one encounters the widely open nasal passage of the nose when, again with a head mirror, one may inspect the nasal passages through to the choanae. Now, however, the width of the inferior meatus is between 2 to 6 mm. and only then may the true function of the nose be appraised by the size of the adenoids, freedom of the airway, presence of purulent secretions, presence of polyps, and mobility of the soft palate with "k" articulation. In order to place the nasal passages in this optimal position for examination, it is always necessary to shrink the passages with a standard solution over a standard time. I have found the insertion of a cotton pledget moistened with 2% cocaine and 4% ephedrine, for 12 minutes in the inferior meatus to be satisfactory for children, first gaining the child's confidence so that crying must never occur. Otherwise, the result is an abnormal amount of mucus and swelling and the "cookie" articulation cannot be performed co-operatively. In addition, the child is requested to smile when the nasal speculum is introduced, because this relaxes the nasal

depressor muscles and helps inspection through the inferior meatus. With normal excursions of the uvula on articulation of "k" the posterior surface of the uvula is seen via the nose to flip upward and backward, sealing off the nasopharynx from the oropharynx. When adenoid tissue is hindering the articulation movement of the uvula, no flipping movement is seen at the choanal level. Failure of the nasal passages to shrink down to the standards of a normal nose, with clear visualization of the adenoid region and absence of any bogginess of the turbinates, always means an anterior infection or allergy, with or without exudate. The role of the adenoids in causing this can be decided only when the choanal aperture is visible. It may not be possible until after several weeks of conservative therapy.

One may question the necessity for such a routine nasal examination, but if the diagnostician draws an analogy between the vestibule of the vagina and the vestibule of the nose, the significance is easily apparent. An opinion regarding the pelvic organs would not be given without employing a vaginal speculum to visualize the cervix. In like manner, a nasal speculum and nasal shrinkage must be utilized to visualize the posterior nasopharyngeal wall through the nose with a head mirror, before giving an opinion regarding a hearing loss. Children were not discharged as normal and cured until this functional nasal respiratory test was normal.

RATIONALE OF TREATMENT

Modern concepts of allergy of the nose are being revised. The role of the psyche (Wolff)[6], and hormonal influence (Selye)[7] is proving that these changes are reversible by self-correcting body factors, and that the necessity for prolonged mentally crippling allergic therapy of these children is, in most cases, a serious error in modern medical practice. Selye showed that the response of the organism to physiochemical stress or a noxious agent is, in general, the same whether the etiology is bacteria, virus, chemical burn, gunshot wound, or allergy.

Although the role of infection in allergy of the upper respiratory passages is not known in all its aspects, this much can be said with some certainty: Bacteria and viruses have a proved local tissue toxicity which, if severe, becomes a generalized toxicity. In addition, many authoritative articles[10-15] have given infections a specific role in promoting localized tissue hypersensitivity reaction and generalized tissue hypersensitivity reactions not at all limited to the bronchi.[8-13]

Therefore, it can be postulated that localized tissue allergy may be temporarily induced in the nasal passages, nasopharynx, and eustachian tubes, and that this same state of allergy may arise spontaneously after (1) local infection, (2) stasis of antigenic secretions in this area, and (3) accumulations of lymphoid tissue of a pathological nature are present for a period of time so as to interfere with normal nasal respiration. Consequently, because of the dynamic state of hormonal balance in the body, this same allergic state may spontaneously disappear after correction of the above three conditions. This I repeatedly have found in these children, verified by remarks of the mother that her child's allergy has completely disappeared after treatment, either medical or combined with surgical removal of the pathological tissue.

The surgical principle of restoring anatomical structures to a semblance of normal must first be carried out. One would not hesitate to incise and drain an abscess cavity if pus were present. Then, if need be, antibiotics are given. Likewise, the allergic child's respiratory passages must be cleared of infected lymphoid tissue and statis secretions before intricate desensitization procedures are done, which in most cases prove to be superfluous.

Finally, the emphasis on a physiological restoration of hearing has previously not been made. Instead, the treatment of hearing loss was related to a particular style of surgery, form of radiation, or finesse of allergy. This therapy seeks to restore normal nasal respiration, normal functioning lymphatics, and normal eustachian tubes, allowing sufficient time for the body's hormones to exert their reparative effects. When this is accomplished, not only does hearing return to its optimum level but the child feels better, eats better, has a better disposition, and the nasal allergies disappear. It must be said at this time that the true irreversible perceptive type of congenital hearing loss can never be recovered by the concept of physiological restoration.

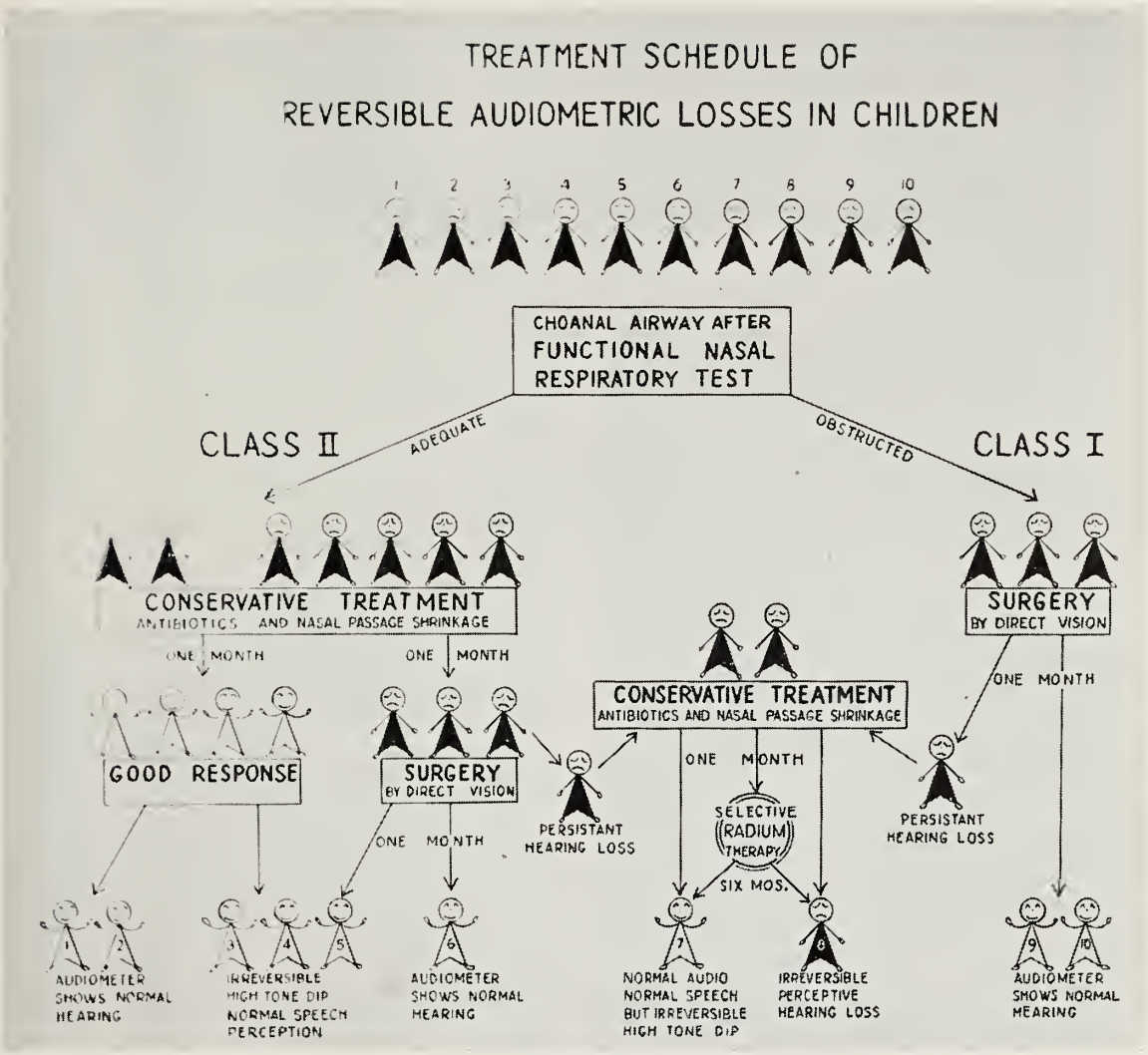


Figure 2

METHOD OF TREATMENT PROCEDURES

Initial Routines: After the functional nasal respiratory test is performed, the nasal passages are in optimal attitude for the direct aspiration with suction pump of retained secretions lying tenaciously in the nose. After the audiogram is procured, the patient is given nose drops, (¼% ephedrine in physiological saline) and careful instructions are printed on the correct method of their use. This procedure alone was sufficient to restore normal hearing in one to three weeks in 20% of the cases. It must be understood that none of these cases was afflicted with the common upper respiratory disease which lasts for a few days to a week to two and then spontaneously resolves. All had had complaints or signs of difficulty for months to a year in duration. Therefore, improvement cannot be ascribed to anything but these measures.

When the patient returns, a recheck of the audiogram will reveal not only any improvement that resulted but will serve to confirm the quality and quantity of the hearing loss. In any event, only after the choanal aperture can be visualized can it be immediately determined if lymphoid tissue is a factor in causing impairment of the nasal airway. For this diagnostic point, one cannot rely on tactile clews or statements of history by parents. If over half of the choana is occluded, surgical removal of all lymphoid tissue by direct vision is necessary[14-16] even if nasal sinus infection or allergy is present. These are called Class I cases (mechanical obstruction of airway). (Figure 2.) Thirty percent of all cases were of this type.

Routine check one week after surgery will reveal a normal or abnormal functional nasal respiratory test. If normal, no treatment is necessary for the next four weeks after which the nasopharyngeal mucosa is healed and a "post-op" audiogram may then be obtained. If the test is abnormal, active conservative treatment must be instituted in order to effect a normal response by the time the "post-op" audiogram is taken.

At this time cases that still have a significant hearing loss (about one-third) are handled like the Class II cases (those with adequate choanal airways). These Class II cases are first given definitive conservative treatment with adequate courses of Gantrisin® and then one of the broad spectrum antibiotics. Transillumination of the sinuses must be abandoned as office procedure because it can light up a sinus satisfactorily and yet not show thickening of the sinal lining as in chronic sinusitis, thus lulling the physician into a false sense of security diagnostically. Likewise, improper X-rays, when taken similiarly to X-rays of the skull or of the extremities, often will not show up pathology. This is more dangerous since the X-ray may be "negative" if technique factors such as focal spot size, object film distance, Bucky, horizontal beam, and contrast media are not right. Paranasal sinus X-rays must be routine for all complaints more than several weeks in duration and the technique must delineate the lining of the sinuses, employing a contrast medium if necessary. The Proetz test of displacement with oily contrast media and 72 hour remptying time film are the only certain methods to pick up a chronic subclinical infection in the paranasal sinuses.

Decongestive nosedrops are prescribed for home use and weekly office dilatation and aspiration treatments are given, wherein the nasal passages are forced open delicately with shrinking agent on cotton with bayonet forceps as in the F.N.R. test. If sinus disease is present, the Proetz displacement is used. If hearing does not return to normal after one month and the sinuses are normal roentgenographically, then surgical removal of all lymphoid tissue is done by direct vision methods. This lymphoid tissue has undergone pathological changes which are considered irreversible[17] as was found necessary in 30% of the cases. Class II cases are then treated as previously described in conservative treatment of Class I cases. About 10% of all cases remain which would be considered for radium or allergic therapy. Only about one-half of these will persist with significant hearing losses or abnormal F.N.R. test after another month of conservative treatment.

RESULTS OF TREATMENT

Of the 350 cases, 245 or 70% returned to normal hearing within 5 decibels of the zero threshold in the speech frequencies and no "dips" in the audiogram as a result of treatment. An additional 20% returned to normal speech frequency, but persisted with high tone dips, etc. After the use of plain ephedrine nosedrops, 75 cases returned to normal in one to four weeks. Many of the rest needed surgical removal of adenoids and tonsils and in a few, radium was required. Included in the 79 cases which did not improve with treatment are 50 cases who merely had a significant loss in one of the higher frequencies, the "high tone dip" but in whom hearing for speech was normal for all practical purposes. Thus there were only 29 cases or 8% left in the entire group who had a practical hearing loss that did not respond to this schedule. Of these, 17 persisted with unilateral hearing losses, resulting in one "deaf" ear and the other normal. This left only 12 or 3-½% of the total with subnormal hearing for usual speech requirements of the irreversible type. Many of these were found to be suitable for hearing aids. The true etiology of these cases represents postviral disease of early life, the rare congenital types of hearing losses, and long standing conduction type of middle ear disease prior to beginning treatment.

CONCLUSIONS

An analysis of 350 cases of hearing losses in school children, as detected on the audiometer, shows 9 out of 10 to be reversible or without a residual practical hearing handicap. This excludes such obvious causes as foreign bodies in the ear canal, cerumen, suppurative otitis media, external otitis, and serous otitis with effusion. Evidence has been presented to show the reversibility of hearing losses, including those that would have been considered perceptive in type, many of the "congenital dip" types having returned to normal. [18-21]

A physiological approach to treatment confirmed the all important role played by the lymphatics of the middle ear and eustachian

tube and the relationship to the etiology of the hearing loss was hypothesized as due to local lymphatic stasis of the conduction mechanism arising from an acquired respiratory nasal tissue hypersensitivity, or allergy in agreement with Selye's localized adaptation syndrome.

A functional nasal respiratory test was used as the diagnostic index in deciding whether medical or surgical therapy was needed for these hearing losses in children.

The school hearing survey is an important detection method and should be supported by organized medicine because, by projecting these results on a national scale, millions of children can be saved from permanent hearing handicaps while in school and in later adulthood occupations.

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Enzymatic debridement

Progress in the treatment of infected wounds with enzymes has been of sufficient degree to indicate the permanent usefulness of these agents. Proper use of the enzymes demands a knowledge of the substrates (fibrin, pus, and necrotic tissue) upon which they act and of the environmental factors which govern their actions. Varidase and tryptar are the forerunners of a battery of enzymes which will be applied to specific substrates in infected wounds. *Joseph M. Miller, M.D. and Milton Ginsberg, M.D. Enzymatic Debridement. Maryland M.J. March* 1956.

The unsolved problem

The process of fermentation became a problem of mankind probably long before Shem and Japhet covered their drunken father's nakedness, and the art of the distiller has done little to abate it. Attempts have been made over the years to break the spell that drink has cast upon the western world but, based on emotionalism and duress, they have been largely ineffective. Only the faith of Islam seems to have been relatively successful in controlling this desire and quenching the thirst. *Editorial. Understanding the Alcoholic. New England J. Med. Aug.* 30, 1956.

The Host in Infection

J. Thomas Grayston, M.D., Assistant Professor of Medicine, University of Chicago
Mark H. Lepper, M.D., Professor of Preventive Medicine
Guy P. Youmans, M.D., Professor of Bacteriology, Northwestern University

DOCTOR SAMTER: Since the advent of antibiotics, the role of the host in infection has been underestimated. We should, perhaps, be grateful to the virus diseases which have resisted antibiotic therapy and re-oriented us toward the importance of host factors in infection. Doctor Mark Lepper has kindly agreed to introduce the topic and the panelists.

DOCTOR LEPPER: It seems safe to say that a discussion of "The Host in Infection" could well encompass a series of seminars throughout the year. Doctors Youmans and Grayson have contributed important findings to specialized segments in the field. Doctor Youmans' work on resistance to tuberculosis and Doctor Grayston's on resistance to virus are on opposite ends of the spectrum and provide an exciting insight into the scope of the problem.

What are some of the interactions between microorganisms and the host? Growth of microorganisms in the infected host has multiple effects which include (1) competition with host cells for food, (2) production of chemical substances or toxins capable of damaging host cells and deranging host functions, and (3) multiplication with spread throughout the host organism. During deterioration, the microorganisms might escape effective removal (persistence of infection) or release damaging intracellular chemicals (endotoxins) at the time of their death. In response to these parasitic and invasive functions, the host relies on reactions which (1) limit the rate of growth, (2) neutralize toxins, (3) limit spread, (4) destroy and eradicate survivors, and (5) remove their remains.

The tools which the host organism utilizes in these defenses include: (1) an integrated set of immediate reactions, e.g., the action of cilia, flow of body fluids across mucous membranes, or the movement produced by smooth muscle peristalsis; (2) protective cells, such as the special cells which resist microorganisms at the portals of entry; the presence of enzymes like lysozyme produced by such cells; the existence of a "normal flora" in various tracts which antagonizes the growth of invading virulent microorganisms; and the availablility of highly specialized host cells of the phagocytic and reticulo-endothelial series which ingest. destroy, and eradicate the infecting organism; (3) substances in the blood stream of the host which are part of his defense against microorganisms; antibodies producing immobilization, agglutination or lysis of microorganisms; complement which participates in antigen-antibody reactions; properdin which potentiates protective mechanisms; perhaps, mucoproteins which compete with cell surfaces for virus attachment; and proteolytic enzymes which may influence the degree and duration of inflammation; (4) non-specific chemical compounds which inhibit microorganisms such as lactic acid, which is decreased in diabetes mellitus and might explain, in part, the poor host resistance in diabetic patients; polypeptides like the polylysines with similar action; steroid hormones which seem critical in efficient host response to infection; maintenance of oxidative phosphorylation through the Krebs' Cycle; and adequate supply of choline since choline deficiency has been associated with decrease in reticulo-en-

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dothelial activity; and finally, (5) physicochemical factors such as the elevation of temperature and localized inflammatory reactions. With this general introduction to guide us, I would like to ask Doctor Youmans to talk to us about his work, the relationship between the tubercle bacillus and the response of the host.

DOCTOR YOUMANS: The discussion of this subject is complicated by the fact that past efforts have resulted in no adequate explanation of the mechanism of immunity or resistance to tuberculosis. No antibody appears to be involved in immunity to tuberculosis and no chemical, no enzymatic, metabolic or hormonal or tissue inhibitory substance has been found to correlate with host resistance in mycobacterial infections. No chemical or enzymatic property has been found in the tubercule bacilli that correlates with clinical virulence. This phenomenon is in contrast to the behavior of many other organisms which do show such correlation. Host resistance to the tubercle bacillus seems to be mediated through phagocytic cells but the particulars are still unknown. When phagocytic cells ingest virulent tubercle baeilli, three possibilities ensue: (1) the infecting bacilli may be completely destroyed - this, of course, means clinical and baeteriological cure; (2) the bacilli may establish a steady state within the host, remaining viable for years after the initial infection, but never progressing beyond a certain limit - this might mean clinical recovery but bacteriologic persistence; or (3) the invading bacilli may multiply at a rate greater than the defensive potential of the host - this means, first, a progressive spread of the area of infection and eventual severe clinical disability or death.

Tubercle bacilli have been divided into three types on the basis of multiplication in the host: (1) virulent bacilli which show rapid multiplication, and, accordingly, progressive extension of disease; (2) attenuated bacilli which show limited multiplication, but no progression of infection; and (3) avirulent bacilli which have lost their capacity to multiply or to produce disease in the host. Thus, the course of infection with tubercle bacilli has been to some extent correlated with rates of their multiplication.

To study this problem, we developed reliable techniques for the determination of rates of multiplication of bacilli in the organs of mice, the description of which would exceed the time limits of this diseussion. We used virulent, attenuated, and avirulent bacilli and infected both immunized and non-immunized mice of known "resistant" and known "susceptible" strains. The number of organisms in lungs, liver, and spleen was determined throughout the eourse of the infection.

Attenuated and avirulent organisms did not multiply in the organs of mice of either "susceptible" or "resistant" strains. Virulent mycobacteria, on the other hand, increased in number. Mice infected with large numbers of virulent tubercle bacilli died of the progressive infection. Mice injected with small numbers of tubercle bacilli survived for prolonged periods and it was shown that multiplication of the tubercle bacilli in the organs of these animals had ceased.

No multiplication of virulent tubercle bacilli could be detected at any time in the organs of immunized mice, but the microorganisms remained viable in the tissues.

Experimental infections of guinea pigs with tubercle bacilli confirm these findings in principle, but guinea pig tuberculosis is commonly a disease of the liver aud spleen whereas tuberculosis in mice is predominately a pulmonary disease. In man, tuberculosis may be present for many years, and spontaneous regression of the infection may occur. Non-specific decreases in host resistance are often accompanied by a progression of the disease, and cases of "arrested" lesions often show large numbers of persistant virulent organisms. Finally, chemotherapy may have a profound effect on the interaction between host and microorganism. However, it would appear that the degree of acquired immunity whieh develops in the host during infection may be the crucial factor which determines the course of the infection.

DOCTOR Walter WOOD, Instructor in Medicine: What is the effect of the injection of additional bacilli during stable infection without progressive disease?

DOCTOR YOUMANS: I cannot answer conclusively. Animals in such a state are immune, at least to some degree, and are generally more resistant to further inoculation. I might add that it is not known whether such immunity is dependent on antibody or phagocytic cells or both.

DOCTOR SAMTER: Your introductory remarks suggest that sensitization to tubercle bacilli does not alter the resistance of the host — is this correct?

DOCOR YOUMANS: I have been unable to implicate allergic mechanisms, but I feel that this statement is based on opinion rather than experimental evidence.

DOCTOR LEPPER: Thank you Doctor Youmans. Doctor Grayston will now discuss the investigative work on virus infections done by the University of Chicago group and the effect of immunity of the host on the course of experimental influenza.

DOCTOR GRAYSTON: The studies by Doctor Clayton G. Loosli and his co-workers which I am about to describe, concern pathogenesis and pathology of experimental influenza virus infections in mice. Pulmonary infections are produced by cloud chamber exposure of large numbers of animals simultaneously to uniform concentrations of nebulized influenza virus aerosol. Mice of identical strains were classified according to the state of their immunity to influenza virus measured by hemagglutination — inhibitory titer of serum. The series included control animals: animals which had recovered from sublethal air-borne influenza infections; animals injected intraperitoneally or subcutaneously with killed influenza virus (vaccine); and finally previously untreated animals which were passively immunized by the injection of serum of low, medium or high immune titer.

Natural immunity following recovery from infection; or immunity following intraperitoneal injection of killed virus, prevented both virus proliferation and death of the host, even after inhalation of more than one thousand times the lethal dose of virulent virus. Control animals succumbed quickly to virus inhalation. Subcutaneous injection of killed virus gave lower antibody titer than intraperitoneal injection and permitted some virus growth in the host, but all animals survived: and antibody titers rose, subsequently, to the usual post-infection recovery levels.

In animals given, passively, antibody of varying titer, protection against death correlated directly with the antibody titer of the injected serum. Virus proliferation occurred in all mice receiving immune serum: the antibody titer declined after exposure so that in those which recovered, no circulating antibodies were found after recovery. When these animals were re-challenged, however, they were frequently resistant to the inhalation of virus despite the absence of serum antibody. The decline of their serum hemagglutinating antibody titer to zero values after their first exposure suggests that the injection of antibodies from immune donors prevented in the recipient, production of humoral antibodies, perhaps by preventing viremia. However, some sort of local protective mechanism was stimulated. It may be postulated that the original infection may have produced a cellular immunity in their lungs.

The lungs of non-immunized animals which survived infections often show marked parenchymal scarring with bronchial metaplasia suggestive of carcinomatous changes while previously immunized animals showed only minimal parenchymal lesions with shedding of bronchial cells and complete recovery.

DOCTOR Alan D. Rapp, Resident in Medicine: Docs virus proliferate in animals which have survived a first infection under passive immunity; and are re-challenged in the absence of serum antibody?

DOCTOR GRAYSTON: Yes, it does, but fails to cause parenchymal lesions or bronchial metaplasia.

DOCTOR Louis C. Johnston, Clinical Assistant in Medicine: What keeps the passively protected animals from producing their own antibodies?

DOCTOR GRAYSTON: Viremia may be necessary for humoral antibody production; and this viremia is apparently prevented by passive immunization.

DOCTOR WOOD: Is the titer of hemagglutination-inhibiting antibody a reliable index of virus-neutralization ability?

DOCTOR GRAYSTON: In general, the correlation is satisfactory.

DOCTOR William R. Best, Assistant Professor of Medicine: It there a possibility that resistance to re-challenging represents an augmented anamnestic antibody response?

DOCTOR Harry F. DOWLING, Professor and Head, Department of Medicine: It would seem that the lack of an early rise in antibody titer would speak against an anamnestic mechanism.

DOCTOR Adolph ROSTENBERG, Jr., Professor of Dermatology: How long after infection modified by passive antibody have mice been resistant to reinfection?

DOCTOR GRAYSTON: In one experiment this non-humoral protection was shown to last at least thirteen weeks.

DOCTOR JOHNSTON: Do properdin levels vary in these infections?

DOCTOR LEPPER: Properdin is a most interesting substance and deserves, I believe, a seminar of its own. In many aspects of host resistance, the gap between theoretical knowledge and practical application is not yet closed. Tuberculosis is still among us and Doctor Grayston's suggestion that host resistance might be based on cellular as well as humoral antibodies has considerable practical importance. It might help us to decide, for instance, whether our present attack on polio which makes use of the parenteral administration of killed virus (Salk), or the exposure to attenuated live polio virus (Sabin), which is now under scrutiny, will be our final answer for the control of diseases of this type.

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How to keep your name aglow

My young friend came to me last night with a rather tricky problem. How could he make his mark in medicine by Jan. 10, he asked. I inquired why then, and it turned out he was getting married then and wouldn't have the time afterward. I asked for further details. Had he discovered any new disease? No, he said, not even a measly syndrome. How about a new drug or a missing factor in a disease no one had ever heard of? No again, he said, he couldn't remember having discovered anything like that lately. Very well, then, I said, let's think of some titles and perhaps you can think of a disease to fit them. How about Hogmanay disease or a dermatological rash involving the skin or the Bolus No. 9 disease? My young friend shook his head sadly, like a membership censor enjoying himself. I was struck by an inspiration. Have you written an article, I asked. No, he replied. I was surprised — after all he had been qualified four months. In that case, I said, there is only one thing to do if you want to make your mark in medicine by Jan. 10 and that is to write an article. My young friend protested. He had nothing to say, he said. Why should he be different from the others, I asked. He was moved by my logic. What subject should he write about? So far he has done only locum surgeries at Shepherd's Bush. Excellent, I exclaimed. You must write an article on medical education. Call it Thoughts from a Surgery in Shepherd's Bush. Will that suffice, he asked. Assuredly, I said. Make a few nasty noises about the medical curriculum and say that anatomy and physiology should be scrapped and that clinical work should start in the first year. Insist that consultants should be apprenticed to G.P.s for at least a year and then not allowed back into their wards at all. Will anyone take it, he asked. Take it, I exclaimed, they'll clamor for it. All they have just now are articles on serum levels in aboriginal half-castes in Outer Bessarabia. Besides they are always printing articles on medical education. And will that make my name in medicine by Jan. 10, he asked. Certainly, I said, and not only that — the correspondence that follows will keep your name aglow for at least a year. *In England Now. Lancet. Sept. 29, 1956.*

Adrenocorticotropic Hormone (ACTH) in the Treatment of Barbiturate Poisoning

K. Chrysanthia Kubota, M.D. and Arthur Bernstein, M.D., Chicago

THIS study was undertaken in an attempt to determine the effect of ACTH therapy upon coma which follows ingestion of excessive amounts of barbiturates.

Twelve patients with acute barbiturate intoxication were treated with ACTH (Armour). These cases were grouped according to the classification of Reed et al[1] which is based upon the degree of depression of the central nervous system, of the respiration, and of the circulation. Thus the patients were classified as belonging to O, I, II, III, or IV; however, since all of the patients in this reported series were comatose none met the requirements of Group O. The cases were difficult to classify because of the occasional overlapping; one system may be more readily affected than another. For example, the nervous system or the respiratory system may be depressed or the circulatory and respiratory systems may be depressed with no depression of the nervous system. In such instances the cases were placed in that group wherein the greatest number of criteria were fulfilled.

All patients treated with ACTH were admitted to the hospital in deep coma. A complete physical examination, performed on admission, was followed by periodic re-examination of the temperature, pulse, respiratory rate, blood pressure, cardiac and pulmonary status, state of consciousness, pupillary size and reaction to light, muscle tonus and response to pain. Neurologic examination was done and the reflexes were graded as follows: 0 for areflexic, 1 plus for hypoactive, 2 plus for physiological, 3 plus for hyperactive, and 4 plus for pathologic hyperactivity. Pain was estimated as follows: 0 for no response, 1 plus for minimal, 2 plus for mild, 3 plus for moderate, and 4 plus for maximal response.

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ACTH DOSAGE

ACTH, administered intravenously in doses of 10 to 20 mg. in 1000 cc. of 5 per cent dextrose solution, was given over a period of six to eight hours at a rate of approximately 40 drops per minute. The only deviation from this dosage procedure was in Case IX, the first case treated; here 65 mg. of ACTH in 500 cc. of physiologic saline solution was given. If the patient was not alert after the initial dose, another infusion of 10 mg. of ACTH in 1000 cc. of 5 per cent dextrose solution was given.

Because of lack of space, representative cases in each group will be given. Full discussion of the total number of 12 patients will be found in the discussion of the results and summary.

Group I: In this group of 3 patients is included those who were comatose, but who withdrew from painful stimuli such as venipuncture, slapping, and pinching. There was no circulatory embarrassment and all reflexes were intact.

Case I — J. N., a 44 year old white man, was admitted to the hospital August 22, 1952, at 2:10 in the morning. He had taken seven blue and red sleeping capsules at 11 o'clock the preceding evening. On admission his rectal temperature was 98°F., pulse 92, respiration 14, and blood pressure 100/80. The heart and lungs were essentially normal. The pupils were constricted and did not react to light; the muscles were flaccid with 1 plus response to pain, and the deep tendon reflexes were 1 plus throughout; no pathologic reflexes were elicted. ACTH, 10 mg. in 500 cc. of 5 per cent glucose in water, was begun at 2:30 a.m. One-half hour later the pupils reacted to light and there was increased tonicity of the muscles. At 7:30 a.m., the patient was alert and co-operative, with no change in the temperature, pulse, respiration and blood pressure.

Comment: Response to ACTH in five hours.

GROUP II: In this group of 2 patients is included those who did not withdraw from painful stimuli but who had no respiratory or circulatory depression. Most or all of the reflexes were intact.

Case IV — C. S., a 55 year old white man, was admitted to the hospital August 7, 1952, at 10 o'clock in the evening. He was a chronic alcoholic and morphine addict who had taken an unknown amount of Seconal Sodium®. The time of ingestion was also unknown. His rectal temperature was 100° F., pulse 128, and the respiratory rate was 14 per minute with gasping respirations. The blood pressure was 30 mm. Hg. systolic, and the diastolic pressure was not obtainable. The antecubital veins were thrombosed, the heart tones embryonal, the chest emphysematous, and the breath sounds distant; multiple abdominal scars were noted. The pupils were unequal, the left measured 7 mm. in diameter and the right 4 mm.; they did not react to light. The muscles were flaccid with 1 plus response to pain, and the deep tendon reflexes were 3 plus; no pathologic reflexes were noted. One-half hour after admission, i.e., at 10:30 p.m., 20 mg. of ACTH in 1000 cc. of 5 percent glucose in water was started. At 11:00 p.m., the blood pressure was 110/90 and the pulse was 100, but the patient still apeared to be in shock. At 8:00 a.m., on the following day, the patient was awake and groaning; the pupils remained unequal.

Comment: Despite the apparent circulatory depression manifested by the extreme lowering of blood pressure this case was placed in Group II. There was a rapid rise in blood pressure with the use of ACTH. It was not known if morphine was taken simultaneously with Seconal®. A good response was obtained.

GROUP III: In this group of 3 patients is included those in whom all or most of their reflexes were absent, but who had no depression of respiration or circulation.

Case VI — D. G., a 27 year old white woman, was admitted to the hospital July 26, 1952, at 5:30 o'clock in the afternoon. She had taken an unknown amount of pentobarbital sodium 75 minutes previously after having drunk an unknown amount of alcoholic beverages. Her rectal temperature was 99° F., pulse 96, and respiration 24. The heart and lungs were normal. The pupils were miotic and did not respond to light; the muscles were flaccid, the response to pain was absent, and the deep tendon reflexes were absent but the pharyngeal reflex was present. At 8 a.m., the blood pressure was 90/60, and pulse 96. ACTH, 20 mg. in 1000 cc. of 2.5 per cent dextrose and 0.4 per cent saline, was begun. Two hours later at 10:00 a.m., the biceps, triceps and radial reflexes were 2 plus, and the pupils reacted to light. At 11:00 a.m. the patient responded to painful stimuli and the knee jerk, ankle jerk and plantar response had returned. The blood pressure had risen to 120/60, pulse 84, and respiration 12. At 10 o'clock that evening, 14 hours after ACTH therapy was begun, the patient was semicomatose and at 7:00 a.m., the next day, the patient was fully awake and the reflexes had returned to normal.

Comment: Good response was obtained to ACTH therapy alone.

GROUP IV: In this group of 4 patients is included those in whom all or most of their reflexes were absent and who had respiratory depression with cyanosis, or circulatory failure and shock, or both.

Case IX — C. H., a 28 year old negro woman, was admitted to the hospital June 17, 1952, at 2 o'clock in the afternoon, having taken Nembutal® gm. 1.0 and an undetermined amount of morphine sulphate at an unknown time. On admission her rectal temperature was 99.4° F., pulse 100, respiration 22, and blood pressure 85/60. The skin was cold and cyanotic, and the pupils were markedly constricted and did not react to light. The muscles were flaccid, there was no response to painful stimuli, and the deep tendon reflexes were absent but no pathologic reflexes were elicited. The antecubital veins were thrombosed. The patient was given picrotoxin 3 mg., 1000 cc. physiologic saline solution, and 4 cc. N-allynormorphine HCl prior to instituting therapy with ACTH. At 3:55 p.m., 65 mg. ACTH in 500 cc. physiologic saline was given intravenously. Ten minutes after starting ACTH therapy, the blood pressure was 134/80, the pulse was 1 plus, and ankle reflexes were present. During administration of ACTH, the patient received 33 mg. picrotoxin, 5 cc. Metrazol® per intravenous route, and 100 mg. Benzedrine Sulfate® by rectum. On the following day at 9:00 a.m., 17½ hours after instituting therapy with ACTH, the patient mumbled, the blood pressure was 120/80, pulse 80, and the deep tendon reflexes were 1 plus.

Comment: A good result was obtained in this seriously depressed patient who received supportive therapy and specific morphine antidote, in addition to ACTH.

Case XI — E. K., a 46 year old white man was admitted to the hospital September 1, 1952, at 7:30 in the evening, having taken an unknown amount of phenobarbital some time prior to admission. His pulse was 104, blood pressure 92/56, and respiration 8. The thyroid isthmus was moderately enlarged and the gland soft to touch. The pupils were markedly constricted and did not react to light; the muscles were flaccid and there was no response to pain; the pharyngeal reflex was absent but the deep tendon reflexes were 3 plus. At 7:40 p.m., 20 mg. ACTH in 1000 cc. of 5 per cent glucose in water was begun. At 8:00 p.m., a gastric lavage precipitated laryngospasm and an endotracheal intubation was done. Tracheotomy was deferred in view of the enlarged thyroid gland. At 7:30 a.m., the pulse was 92, blood pressure was 110/60, and respiration 3. At 12:30 p.m., the blood pressure and pulse rate remained the same, but the respirations had increased to 6 per minute. At 2:00

p.m., 6 mg. picrotoxin was given intravenous. The patient's condition remained poor and he died at 8:30 p.m., 25 hours after admission.

Comment: Marked respiratory depression probably was cause of fatal outcome.

RESULTS

The overall mortality rate in the present series was 8.3 per cent, while the mortality rate in Group III and IV together was 14.3 per cent. However, this is not statistically significant because of the small number of cases. The morbidity rate was markedly decreased since those who survived recovered in less than 24 hours. This compares favorably with a much larger series of 144 patients with barbiturate poisoning admitted to the Cook County Hospital during 1950 and 1951 and treated by the usual methods. In the latter series the overall mortality was 12.1 per cent and in Group III and IV was 47 per cent. The morbidity in this conventionally treated series was also significantly greater since 30 per cent of patients required more than 24 hours to recover.

In 7 of the 12 reported cases, adjunctive therapy usually recommended for barbiturate poisonings[2-11] had been given and may have contributed to the patients' recovery. This is especially true for Case IX; in Cases II, III, X, and XII it seems unlikely, and in Case VI no conclusions can be drawn as the exact quantity of the ingested agents is unknown.

How ACTH works in barbiturate poisonings can only be theorized. However, we offer the following:

1. Alcoholic beverage consumption in conjunction with barbiturate ingestion was noted in 6 cases, i.e., II, IV, VI, VII, X, and XII. It is known that alcohol enhances the barbiturate effect. ACTH has definite beneficial effect in the treatment of alcoholism and may also antagonize the synergistic effects of alcohol[11-18].
2. ACTH increases the glycogen storage of the liver which must detoxify most of the barbiturates[19-21]. In all of the cases except IX, some form of intravenous glucose solution had been administered, further helping to protect the liver.
3. ACTH had no effect on the blood pressure per se[22-25] but intravenous infusions aided in elevating the blood pressure in patients with shock or hypotension.
4. ACTH produces progressive increase in glomerular filtration[26-28] which may help eliminate those barbiturates which are partially excreted by the kidney.
5. ACTH improves cerebral stimulation[29-35] and thereby decreases the morbidity period.

Except for Case IX, the ACTH dosage was small and as such would not be harmful to the body. A single dose as high as 200 mg. produces no harmful effect.

SUMMARY AND CONCLUSIONS

This is a report of 12 patients with barbiturate poisoning treated with ACTH in some type of intravenous solution, with favorable results. The series herein is too small for final conclusions. However, since the morbidity and mortality are lower, it is strongly recommended that further investigation be done on the use of ACTH in acute barbiturate poisonings. Studies should include the antidotal mechanism of ACTH in terms of medullary (respiratory and circulatory) effect, cortical (awakening) effect, and barbiturate destruction.

In view of the one fatality reported in this series, it is cautioned that should no signs of improvement occur in the first six to eight hours after initiating ACTH therapy, one should administer the usual recommended analeptics, such as picrotoxin and Metrazol; according to statistical data the mortality rate is directly proportional to the duration of coma.

25 E. Washington St. (A.B.)

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X-ray and leukemia

Dr. W. M. Court Brown described one particular investigation — that into the association between leukemia and therapeutic X-rays. This was a good example of the value of a statistical inquiry based on existing records. The survey was concerned with the fate of some 13,000 patients treated for spondylitis at 79 radiotherapy centers during a 20 year period, and showed that in these patients the mortality from leukemia was at least nine times the normal expectancy. Subsequent work had shown no such association with patients with spondylitis not treated with X-rays. It is reasonable to conclude, therefore, that the increased mortality from leukemia was the direct result of exposure to therapeutic X-rays. *Medical Statistics. Cancer and Leukemia. Brit. M.J. Oct.* 6, 1956.

Freedom in Medical Practice

Dwight H. Murray, M.D., Napa, California

ALMOST six months have elapsed since we last met to deliberate and act on medical affairs. The time has passed quickly, but not quietly.

The rumble of war and revolution has resounded in our ears. The din from political battles has been deafening.

All of us . . . sooner or later . . . learn that today's events do not just swirl around us, but involve each of us. As doctors we cannot get away from them by claiming that our only interest is in the sick, and that we cannot be bothered by political, social and economic problems. These matters demand attention from the doctor as well as the lawyer, the businessman, the newspaper editor, the labor leader and the worker.

If we are concerned about what happens on the international, national and local fronts — and we should be — then certainly we cannot afford to be disinterested in what happens in our own area of health and medical affairs. Yet there is apathy in our ranks.

REPLACE APATHY WITH ACTIVE, UNITED PROFESSION

Today there is a greater need for a united, forceful and informed profession than ever before. We have been caught in the throes of a social revolution which demanded something for nothing. Changes have been taking place all around us, and medicine has not escaped unscathed.

For example, in a few days Public Law 569, the bill providing medical care for military dependents, becomes effective throughout the land. Contracts already have been signed with the government by the majority of our state societies. No longer can any doctor claim that this law does not affect him. No longer can he say that government laws really are not changing the practice of medicine.

Public Law 880, better known to all of us as H.R. 7225, is another case in point. Medicine now is facing the problem of protecting the taxpaying public from abuses and of co-operating with the government to carry out the provisions of the law. The law is now on the books, and we must provide the leadership necessary to make it work as well as possible.

It was encouraging to hear Ezra Taft Benson, Secretary of Agriculture, say last week before the American Association of Land Grant Colleges and Universities:

"Sooner or later, the accumulation of power in a central government leads to a loss of freedom . . . Raids on the federal treasury can be all too readily accomplished by an organized few over the feeble protests of an apathetic majority. With more and more activity centered in the federal government, the relationship between the cost and the benefits of government programs becomes obscure. What follows is the voting of public money without having to accept direct local responsibility for higher taxes. . .

"If the present shift of power from state to federal authority which started 25 years ago is allowed to continue, the states may be left hollow shells."

It was encouraging to hear such comments from a member of the President's Cabinet. I only wish that all members of the official family, and more important, every member of the United States Congress, felt the same way.

The expression of this philosophy, with which medicine so heartily agrees, sounds good, but putting it into practice is the thing we are really interested in.

Today the medical profession along with business and industry is caught between those who desire to promote sound government programs and those who desire even more intensely to perpetuate party power. Unfortunately, in recent years a benevolent federal government appears more attractive to the voting public than the preservation of individual freedoms. Medicine must do its utmost to reverse this trend.

Address of The President, A.M.A. Clinical session, Seattle, Washington, Nov. 27, 1956.

MEDICAL FREEDOM ESSENTIAL

In my travels around the country as your representative the last 18 months, I have seen little dissension or rancor within our ranks. However, I must report that I have seen too much complacency over governmental encroachment into medical affairs. And I am deadly serious when I say to you that apathy by the few, or by the many, can be detrimental to all.

No nation can merely reap the benefits of freedom; it also must sow seeds of freedom.

In medicine the situation is the same. If an apathetic medical profession takes its freedom for granted, it will be the beginning of the end. A strong, free profession must work for freedom so that it may live in freedom. And history tells us that once medicine loses its freedom, other fields of private endeavor are immediately in danger.

I do not wish to paint a dark or distorted picture of medicine's free status and its stature in America today. But I do believe words of caution and an appeal for vigilance are in order.

The road of apathy and disunity can only lead to disorder and perhaps disintegration, and we must sound a warning to all our colleagues who don't care, or who are pulling in the opposite direction. The road of alertness, action and unity is the proper road for all of us to be traveling together.

If I had just one wish for the coming year, it would be to command the time and talents of the 160,000 physicians in the American Medical Association. I would set us all to the task of emphasizing and re-emphasizing the absolute necessity of patient and professional freedom.

PATIENT'S RIGHT TO CHOOSE HIS DOCTOR

I believe it is one of our prime responsibilities to prove to our patients that their right to choose their doctor is a most important one.

Free choice brings a bond of confidence between doctor and patient which no compulsory medical system can create. It means that the patient knows the physician will be interested in him as a person, not as just a serial number or the 2:45 appendicitis case.

For the doctor free choice means that the patient has selected him for his abilities, training, sincerity and personality. When a patient comes into my office, I know he has made a choice. And from that moment there begins a physician-patient relationship of the highest order. To me the patient is someone special, and I in turn hope that I am someone special to him.

Once the patient has made his choice, the physician automatically assumes an unqualified responsibility to the patient. No system of medical care that uses a third party to bring doctor and patient together can match our kind of cooperative performance for the treatment of illness, the cure of disease and the betterment of the patient's health.

Freedom to select a doctor is part of everyone's great freedom to choose — to choose what he wears and eats; where he works and worships, and how he votes. Take away any part of this freedom and great damage is done to our democratic system.

FREE CONDUCT IN MEDICAL TREATMENT

Another freedom closely tied to freedom of choice is freedom in the conduct of medical treatment.

At the recent meeting of the World Medical Association in Havana, Cuba, Dr. Rolf Schloegell of Germany made a stirring defense of free conduct of medical treatment. He told us that the medical profession believes the attending physician alone is competent to decide what measures he deems necessary and will apply in order to bring about the desired improvement. He warned too of the danger of excessive restriction on the freedom of the patient and the attending doctor.

Yet the trend toward extending social security in the medical care field has been steady and has accelerated since the end of World War II.

The dangers of shifting responsibilities for medical care from the patient and doctor to the government are obvious. The caliber of medical care cannot be as high when both patient and doctor are dependent upon government. Initiative succumbs to dictation, and self-reliance is replaced by the crutch of government.

We do not deny that there is an area of legitimate concern by the government for the health and welfare of the people. But each year government seems to extend that area. We get some idea of this expansion from the new federal medical budget.

This year, according to our Washington Office, the average family will be paying $54.61 for the U. S. Government's health and medical

activities. And the total expenditures this year amount to 2½ billion dollars — 290 millions more than last year. Even in an overall federal budget of 61 billion dollars, the total health cost of 2½ billions is not insignificant. It is a billion dollars more than the cost of running the Commerce Department, half a billion more than the Agriculture Department and six times more than the Interior Department's budget.

Many expenditures obviously are necessary to keep up our unsurpassed public health standards, and research may pay rich dividends in scientific discoveries. But there is no doubt that much money is being spent on medical activities that should not involve government participation.

The trend is to spend more and more government money on health and medical matters because it is good politics. Apparently many Americans still want to see government in the role of a big brother, dishing out so-called gifts and bargains under the guise of benevolent economic planning.

I believe it is our duty, as it is everyone else's, to combat the attitude of "what's in it for me?" and to promote the long-honored creed of "what's best for all Americans and our free society." I think that a nation can drift into state medicine inch by inch just as surely as if the scheme were foisted upon a people overnight. The "drift" method may take longer but the result will be the same.

So it is time all of us sounded the alarm against soft and superficial security and against the invasion of personal responsibility. It is time we stood up together for militant freedom and for full rights and responsibilities of the individual.

BELGIAN DOCTORS TURN BACK GOVERNMENT

There is no better example of what a unified medical profession can do than in the story of the recent fight of the Belgian doctors against the government's proposals for a state service of medicine.

Without consulting the medical profession the Belgian government proceeded to draft rules and regulations of health to be incorporated in the nation's social security legislation. Under the proposals doctors were to sign an agreement to abide by the present rules and any later regulations. For the patient there would be the usual red tape in getting medical care.

When the Belgian doctors learned of the scheme, they met in conference with the government. They told the government what they wanted and what they would not accept. The government agreed.

For several months everything was quiet. Then the Belgian doctors suddenly read about the new health bill that the government was sending to Parliament. It was quite contrary to the earlier agreement worked out by the profession and the government. But the bill was passed quickly.

The Belgian medical profession protested and said it would not be placed under the Ministry of Labor. Instead the doctors proposed to set up their own plan of medical assistance.

Before long, the government saw that the medical profession meant business and that the doctor's plan was an attractive one. So it declared that its own bill was not in force and could not be in force without the consent of the medical profession.

To me this fight against legislative intervention in medical care is excellent evidence that the profession can defend itself if it unites to defend the basic principles of freedom and if it offers constructive proposals. By using the Belgian national motto, "in union there is strength," the medical profession showed doctors everywhere that dangerous government plans can be turned aside by the strong.

I also read recently in the Journal of the World Medical Association of the fight of the medical profession of Malta against a British government scheme to introduce a full-time salaried medical service, without the right of private practice, on an island dependency of Malta. Here again the doctors reacted with unity and strength, and successfully thwarted the government's plan.

There is a lesson in these stories from Belgium and Malta. They prove that a unified profession has a great political power for good — the good of the patient, the doctors and the nation.

CONFIDENCE OF PATIENTS, UNDERSTANDING OF LEGISLATORS NEEDED

While we are developing unity within our own ranks, I believe it is equally important to continue to build up the confidence and respect

of our patients, and to make our legislators aware of the necessity for freedom in medical practice.

Let us never reduce the quality of service we render to our patients, and never lose the personal touch in medicine. Where there is any opportunity to improve upon our medical care, let us seize it and show our abilities to do an ontstanding job. Satisfied patient-customers will give us deserving support when we need it.

We also should realize that the destiny of medicine can be determined to a large degree in the halls of Congress. If this be true, then it is even more important that we take an even greater interest in those who elect the Congressmen. Sympathetic understanding of our position by federal legislators through the voting public will be an insurmountable deterrent to the forces supporting state medicine.

The day has come, gentlemen, when we can no longer look upon medical economics and social changes merely as issues to be considered during our limited leisure hours. Our interest in them cannot be superficial or intermittent.

We now must pay daily attention to these matters. Medical socio-economic affairs can no longer be just incidental with us. They must be a vital part of our life and of our profession.

Each of us, I believe, should dedicate himself to the words included in the oath of office taken by Presidents of the A.M.A.

"I shall champion the cause of freedom in medical practice and freedom for all my fellow Americans."

As doctors, representatives to the A.M.A. and as spokesmen for the A.M.A., let's remember these words and live by them. And to alter a phrase of President Lincoln's only slightly: Let's make common cause to keep the good ship of medical freedom on this voyage, or nobody will have a chance to pilot her on another voyage.

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The role of the dentist in hepatitis

In this hospital at least, 30 per cent of apparent infectious hepatitis cases in adults actually may be cases of serum hepatitis. At the same time it shows that, out of 22 cases of serum hepatitis over a two year period, 15 (68 per cent) were due to exposure at a dentist's; and seven (32 per cent) to the actual administration of blood or plasma. It appears, therefore, that in this community, serum hepatitis following dental procedures is a considerable public health problem.

For prevention, chemical sterilization should be abandoned. Autoclaving is a choice method of killing the virus but of course it must be used properly. Boiling for more than half an hour may be sufficient. Cleaning of needles and syringes is important. Autoclaving of syringes and needles under conditions of proper moisture, temperature, and length of time, and using a different syringe and needle for each patient, may not be enough if the procaine itself has been contaminated. Since it has been recognized that only 1.0×10^{-4} cc. of contaminated serum is sufficient to produce serum hepatitis, and since syringe contamination in several ways has been well demonstrated, the step from syringe to procaine contamination is certainly plausible. If this has occurred, the procaine bottle with its contents can be autoclaved. We suggest that this be done routinely after each procedure in hospital practice, where many different individuals have the opportunity to use one bottle. *Francis E. Foley, M.D. and Ralph N. Gutheim, M.D. Serum Hepatitis Following Dental Procedures, Ann. Ind. Med. Sept.* 1956.

Ephedrine Serendipity

Ben Seid, M.D., Chicago

While reading Sigmund Freud's Letters to Wilhelm Fliess (1887 to 1902) the author was struck by several references in the introduction pertaining to the "naso-genital reflex neurosis". Fliess claimed that "varying symptoms, pains and disturbed functions of many organs had their origins in the nose and could be ended temporarily by anesthetizing the responsible area in the nose with cocaine". Fliess stated that "the etiology of sexual neurosis frequently assumes the form of the nasal reflex neurosis". He explained this frequency by assuming a special connection between the nose and the genital apparatus, and that "vasomotor endogenous alterations in the nose arose essentially from the sexual organs". A case in point is the vicarious menstruation from the nose in females.

Carrying this analogy further it was but a step to utilize medicaments for the nasal mucosa as intra-urethral instillations empirically. For many years urologists have searched for an ideal topical anesthetic for the urethra prior to instrumentation or cystoscopic work. Thus, the gamut has been run through cocaine and its many derivatives to antihistamines and hypnosis. The one detracting element was the length of time necessary for the anesthetizing agent to take effect- anywhere from five to 15 minutes. Reasoning that if the urethral mucosa were analagous to the nasal mucosa it might also be turgescent under varying conditions, it was decided to try increasing strengths of ephedrine preparations to provide detumescence of the highly vascular urethral mucosa, thereby enlarging the luminal caliber with resulting minimal traumatism by the instrument in use. It was found that a 1% ephedrine aqueous solution served ideally in that it took effect almost immediately and did not cause any significant rise in blood pressure readings even in hypertensive individuals. The incidence of bleeding was greatly reduced or entirely absent in most cases due to both the vasoconstriction and diminished traumatism from the instrument used. Combinations of ephedrine with various "caine" and antihistaminic preparations did not enhance the anesthetic action nor ease of instrument passage, but paradoxically seemed less effective.

Experiments in combination with other drugs are still going on and even better results may be reported at a later date. In the meantime here is a good solution for urologists to use in the urethra, perphaps the best for certain conditions.

RESUME

Aqueous ephedrine 1% is a valuable solution for instillation into the urethra prior to any urological procedure.

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Control of bronchiectasis

Planned medical treatment, especially antimicrobial therapy, can control even advanced cases of bronchiectasis, prevent or delay progression of the disease, and thus rehabilitate many patients. If given vigorously over a prolonged period, conservative therapy can accomplish cure in the early reversible stage of bronchiectasis which is mostly found in children following bronchopneumonic-atelectatic processes not necessarily associated with permanent structural damage. *Walter Finke, M.D. Bronchiectasis. Current Therapy (Howard F. Conn, M.D.)* 1956.

CASE REPORTS

Polyarteritis Nodosa Simulating Appendicial Abscess

R. E. Thompson, Jr., M.D. and B. E. Malstrom, M.D., Galesburg

THE antemorten diagnosis of polyarteritis nodosa is no longer a medical novelty. Although polyarteritis nodosa is still a rare entity, it is encountered often enough to warrant a high index of suspicion in any fever of obscure origin or clinical pictures involving multiple systems.

The following case illustrates an unusual presenting picture of this puzzling and unusual disease.

A 58 year old minister stated that except for fatigability he had felt well until ten days before admission. Then he noted a loss of appetite and a slight dull ache in the right lower quadrant of his abdomen. He did not have nausea, vomiting, or any change of bowel habits. He noted no blood in his stools. One or two days after the onset of pain, his right leg felt hot and feverish. There would be slight pain in the calf and swelling of the right ankle when he walked. The night before admission, he had a slight chill and felt he was running a fever. On examination, his personal physician discovered an abdominal mass in the right lower quadrant. He referred the patient for hospitalization and study.

About one year before this admission, the patient had been hospitalized elsewhere. At that time he had been told that he had an anemic condition and was placed on thyroid orally and liver and vitamin B12 injections. Family history revealed that his father had died at age 84 of unknown cause. The mother had died of pulmonary tuberculosis. The rest of the history of family and patient was not remarkable.

Physical examination revealed a rather pale white man who was weak and perspiring and who appeared acutely ill. Temperature was 101°, pulse 88, respirations 20, blood pressure 122/84. positive physical findings were as follows: There was a tender mass, approximately 8 cm. by 4 cm., in the right lower quadrant of the abdomen just above the inguinal ligament. Rectal examination revealed a small polyp on the posterior wall just inside the mucocutaneous junction. The entire left leg was slightly swollen and measured ¾ inch greater in diameter at the midcalf than did the opposite leg. There was a one plus pitting edema of the right ankle. No nodules were noted on the skin of the extremities or other parts of the body at this time. There was a small right inguinal asymptomatic hernia. Deep tendon reflexes and superficial skin sensations as well as superficial reflexes were normal.

Laboratory Studies and Course in the Hospital: On admission, red blood cell count was 3,590,000; hemoglobin 11.8 gm.; white blood count 14,750; differential count, 72 segs, 3 stabs, 23 lymphs, 2 monocytes. Urinalysis revealed specific gravity 1.031; albumin, sugar, and acetone were negative. Microscopic examination of urinary sediment was reported as negative.

Agglutination tests for typhoid, paratyphoid, and Brucella abortus were negative, as was the OX-19 agglutination on two occasions. Sedimentation rate was 36 mm. an hour (Westergren method). Repeated stool examinations for occult blood were negative. Prothrombin time was 19 seconds, 70 per cent of normal.

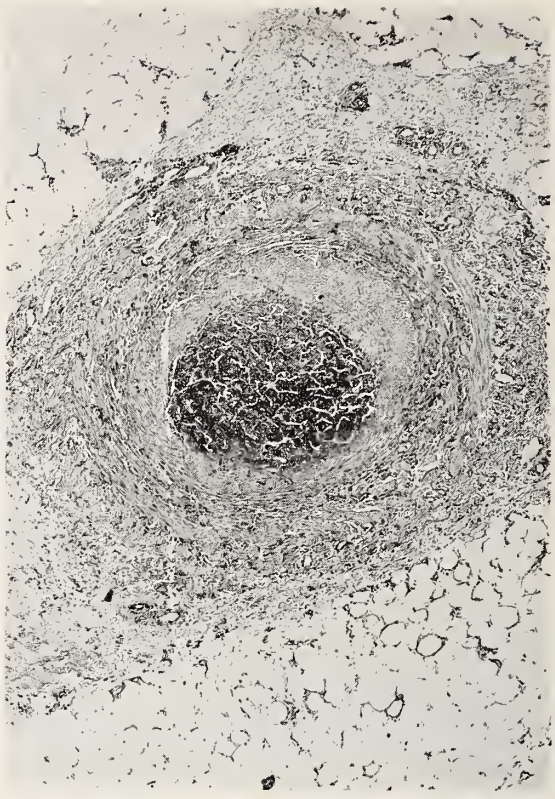
The impression when the patient was admitted was perforated appendicitis with abscess formation, although the findings were not considered typical.

The patient was treated with a low residue diet, elevation, and hot, moist dressings on the right leg. Penicillin, dihydrostreptomycin and later tetracyline, and erythromycin® were given serially. Vitamins, hematinics, and a short course of dicumearol were also given when progressive signs of edema and tenderness of the calf appeared. On his third day in the hospital, the patient complained of fleetings pains in his left calf and of various deepseated pains in other portions of both legs. Proctoscopic examination was negative except for the tiny polyp felt on digital examination. The polyp, on excision, proved to be a benign fibroepithelial growth. Barium enema revealed no abnormality.

Although the mass gradually disappeared in five days, none of the treatment appeared to affect the general course of the patient's disease. Complete blood count was repeated on three occasions, and there was no significant change in any of the cellular components. The temperature ranged daily from normal to 103°: a rise in temperature in the evening was associated with chilly sensations.

The obscure generalized symptoms and development of deep tenderness in the right calf prompted a biopsy of the right gastrocnemius muscle, which was performed on the patient's 21st day in the hospital. The pathologist's microscopic report (Dr. Franz Lengh) was: "Numerous sections fail to reveal any evidence of periarteritis nodosa." The patient's temperature slowly subsided. The patient, slightly improved and having been afebrile for one day, was discharged on his 25 th day in the hospital.

He was admitted a second time thirty days after his discharge. One week after leaving the hospital, he had noticed recurrence of a temperature of 101° to 102° each evening. The high temperature each evening had lasted for about a week and then had disappeared for about a week. Fever had recurred two or three days before second admission. The patient also had noted intermittent cramping abdominal pains and extreme fatigue and weakness when he tried to walk. He again had seen his personal physician, who found a marked anemia. The patient was readmitted for further studies and treatment.



Photomicrograph of lesion in this case demonstrating marked round cell infiltration and fibroblastic proliferation.

Physical examination at this time revealed a temperature of 101°, a small herpetic lesion of the lower lip, slight tenderness of the lower abdomen, but no masses were palpable in the abdomen. Over both lower legs there were small subcutaneous erythematous nodules. The largest was on the right upper thigh. A nodule on the left upper thigh appeared to be regressing. A specimen of the lesion on the left thigh was taken for biopsy.

Laboratory work-up revealed urine profile entirely negative. Red blood cell count was 2,930,000, hemoglobin 8.5 gm.; white blood cell count 11,900, 69 segs., 29 lymphs., 2 monocytes. Sedimentation rate was 39 mm. an hour. Blood NPN was 30, creatinine was 1.15 mg. per hun-

dred cc. Blood culture revealed no growth. The pathologist, Dr. Lengh, reported that the biopsy of the lesion of the left thigh indicated microscopic findings of polyarteritis nodosa. Two other pathologists concurred in this diagnosis.

After 1,000 cc. of transfused blood, the patient was discharged from the second admission on his 10th day in the hospital on hydrocortisone, 20 mg. twice daily. He was returned to the care of his personal physician with the suggestion that hydrocortisone be continued. Within 24 hours there was dramatic relief of symptoms. The patient has been able to work daily as a store clerk and to maintain his duties as a clergyman. After he had been on hydrocortisone for six months, an attempt was made to withdraw treatment. When treatment was stopped, the patient began to feel feverish and noticed the appearance of a nodule on the upper abdomen. Treatment with prednisone, 5 mg. twice daily, was then instituted with prompt alleviation of symptoms, and has been continued to date.

When last examined in July, 1956, more than one and one-half years after onset of symptoms, the patient felt and appeared well. Blood pressure, general physical examination, chest roentgenogram, complete blood count, urinalysis, and electrocardiogram were within normal limits. Sedimentation rate was elevated to 42 mm. in one hour. Positive physical findings were as follows: There was a two plus bilateral pitting edema of the ankles with difficulty palpating the peripheral dorsal pedal and posterior tibial pulses. There were small varicosities extending up from the ankles over both legs and to the level of the iliac crests.

COMMENT

Since this patient has not been subjected to laparotomy and exploration is not planned, the nature of the abdominal mass must be left to conjecture. Speculation is that a mesenteric thrombosis, mesenteric aneurysm, or true appendicial perforation may have occurred as a result of the vascular lesions of polyarteritis nodosa, and that the mass disappeared during the healing process.

The Galesburg Clinic
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Acoustic trauma

The average worker who adapts himself to noise of a meter level below 90 decibels shows very little evidence of acoustic trauma or any other damage to his physiologic or psychogenic health. When the noise level is above 90 decibels, as in shipyards and machine shops, the worker is exposed to intensive noise, and acoustic trauma follows. With such workers, we find that some become inattentive and lose the faculty of listening. It is known that in some hysterical cases, subconscious negation of all or some stimuli to hearing may be present and results in unstable mentality with suggestibility of functional discord in hearing. In this situation, the patient believes his deafness is real. With the malingerer, we know that he is not too deafened and he can be caught by the malingering tests. In testing malingering workers, a small number of cases will be found in which repeated tests show discrepancies and inconsistencies, and the hearing loss will be out of proportion to the pathologic findings. When this is encountered, the psychogalvanic skin resistance audiometer can be used. With this test, the skin resistance induced by sound stimuli will reflect the response of the person to sound at the threshold level. However, this test is not acceptable in many cases of litigation. *J. Coleman Scal, M.D. Hearing Impairment in Noisy Environment. New York J. Med. Sept.* 15, 1956.

EDITORIALS

Malpractice problems

The time to avoid a suit for malpractice is before it occurs. If that cannot be done, the Westchester Medical Bulletin[1] has the following to say:

"Do you know what to do when a patient claims malpractice? Some doctors don't. They talk either too much or too little. While 'There's no foolproof system for avoiding a malpractice action,' concedes J. Joseph Herbert, chief legal counsel for the Michigan State Medical Society, '. . . there are several steps the physician can take to protect himself from the moment any patient indicates dissatisfaction.' "

1. If your patient so much as hints he thinks something is wrong, raise your guard immediately and treat him with polite but noncommittal formality. Remember that malpractice is defined as a breach of duty on the physician's part. A bad result is not proof in itself of a breach of duty. Above all, don't assume gratuitously the blame for a bad result. Speak in carefully chosen phrases.

2. At the first hint of a malpractice claim notify your insurance company. Don't wait until the word lawsuit is mentioned. Phone your carrier as soon as you think the patient might ultimately take action. The company's representatives will be glad to advise you what to do.

3. If suit seems possible, review your office records immediately. Then go to the hospital and examine all relevant records there. Full preparation has saved cases for many a doctor but if any lawyer other than your own asks to see your records, refuse.

4. Always be completely frank with your own lawyer and with your insurance company's lawyers. It is their job to help you, Herbert tells *Medical Economics*[2] readers. They can help you best only if they know all the facts — even the ones you may think unimportant.

5. Finally, if you are sued — or suspect a suit is brewing — seek out some of your own colleagues. Get their advice and help. Don't be embarrassed at telling them the whole story. They may be able to help you decide whether to settle or fight. And they may be able to testify for you, if that should prove necessary.

1. Westchester County M. Bull. 24:23 (June) 1956.
2. Med. Econ. 33:147 (May) 1956.

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Physicians should lead in highway safety

An interesting article appeared in the October 27 issue of The Journal of the American Medical Association on the subject of highway accidents and the physician's role in assuming leadership in their prevention. Recently it was announced that more than 40,000 Americans were killed in highway accidents during 1956, and many thousands were seriously injured. Every 14 minutes someone is killed, and every 25 seconds someone is injured on our highways. "Success in meeting the problem of ever-increasing in-

jury and death on the highways will require the co-operation of the best minds in medicine, highway engineering, and car design".

The A.M.S. has a new committee on the medical aspects of automobile injuries and deaths with Dr. Fletcher D. Woodward of Charlottesville, Virginia as chairman. Dr. Woodward said physicians might be the logical leaders in a coordinated movement because of their biological science background and their intimate knowledge of crash effects and the problems of human behavior that figure in smashups.

Governor William G. Stratton of Illinois has some very definite ideas relative to the reduction of highway accidents and fatalities. No doubt many of these will be presented to the legislature now in session.

Each year, unfortunately, too much emphasis is placed by automobile manufacturers on the increased horsepower ratings and in the top speed of cars. Also it is a well known fact that many accidents today are the result of teenagers speeding and drag racing on the highways. It is most likely that Illinois should have a maximum speed limit; however we must also remember that more attention should be paid to the cars travelling too slowly on our highways, a fact that is responsible for many accidents.

Quite a number of the state medical societies have committees on highway safety. The Illinois State Medical Society has a Committee on Traffic Safety, although to date the committee has been inactive. Physicians in Illinois should become more interested in the highway safety problems and take a more active part in efforts to lessen the current highway hazards.

These problems were called to the attention of the physicians attending the 1956 annual meeting of the Society last May when most of one afternoon was devoted to the discussions of highway accidents with speakers appearing who have devoted much time and effort toward trying to decrease these accident statistics.

Members of the Illinois State Medical Society Committee on Traffic Safety plan to co-operate with the A.M.A. committee in order to avoid duplication of effort. The committee also plans co-operation with the various departments of the State of Illinois involved in traffic regulation and safety programs.

As activities are stepped up and as the work progresses, further reports will be made to the membership of the Illinois State Medical Society through committee statements to the House of Delegates and through articles in the Illinois Medical Journal.

Prevention of traffic deaths is everybody's business, but particularly that of the medical profession where specialized knowledge denotes intensified interest and individual ability.

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Report of a special committee appointed by the Council of the Illinois State Medical Society

The Council of the Illinois State Medical Society appointed a special committee to review a report of the National Advisory Committee to Selective Service with regard to the increasing number of foreign graduates now taking internship and residency training programs within the United States. This committee was informed of numerous complaints from recent graduates of American medical schools, as well as from physicians engaged in active practice, to the effect they were being called into the service of the Armed Forces while the graduates of foreign medical schools were not entering service and fulfilling their military obligation.

According to information in the press, it is believed the Doctor Draft Law may not be continued beyond 1 July 1957. It is anticipated that the Universal Military Training and Service Act, as amended, which affects men born after 30 August 1922, will have special provisions incorporated in it concerning doctors. One of the proposals which may be suggested is that Selective Service Local Boards not call physicians under the regular draft law until a definite need arises for this group.

Statistics were presented showing how many hospitals are employing as residents the graduates of foreign medical schools, exchange visitors and those admitted to the United States on permanent visas. The majority of these residents have been found to hold no medical license of any kind within the United States. This group of residents is the one about which the Committee is receiving complaints.

The graduate of a school recognized by the American Medical Association is found qualified for military service without holding a li-

cense to practice medicine, but a graduate of a school not recognized by the American Medical Association must have a year of internship in a recognized teaching hospital and a full license to practice medicine in any state within the United States. Therefore, should the graduate of a foreign school not secure a full license to practice medicine, he will be found disqualified for military service and administratively rejected for service, going into a IV-F classification the same as one who is physically, mentally or morally disqualified.

Due to the large number in this group within the State of Illinois, it has become quite a problem because the majority of house staffs today are composed of foreign graduates. While not all of these individuals are purposely not securing licenses, there are many who may be avoiding licensure in order to escape military service.

We were informed that some other states are having the same problems, but the states having strict licensure enforcement within their hospitals have not found many of the foreign graduates entering their state. We also understand one state is having malpractice suits involving hospitals employing graduates of foreign medical schools who hold no license of any kind.

A question was raised as to what action would be taken in the State of Illinois should the insuring agencies of hospitals be informed of the tremendous number of physicians who are employed as residents but hold no license, when the state law requires all resident physicians to have some types of license. The staffing of institutions with foreign graduates holding limited or temporary licenses has also become a problem as these physicians are given such licenses and hold them for many years. Many of these individuals realize if they hold such licenses they will not be found qualified for military service. The Department of Registration and Education states: "A limited license may be revoked by the Department at any time after the holder thereof becomes qualified for examination for a regular license to practice medicine according to the terms of this act." It was found many individuals have held limited licenses for three or four years. It would seem if these persons were not qualified for full licensure within this time, they should not be retained at these institutions. Records show there are many graduates of foreign medical schools who have attempted to pass the State Board examination on five or six occasions and are apparently still employed as residents or house staff physicians within the state.

A detailed study has been made and we find there are approximately 178 persons currently engaged in residency training programs within the state who are not licensed to practice medicine. Of this number, a very few hold limited or temporary licenses. This figure does not include the residents in the employ of hospitals not approved for residency training by the American Medical Association, nor does it include physicians who have had years of residency training within the state and are now outside the state taking further specialty training. There are physicians within this group who have had as much as five years' residency training, and some who have completed residency training and are now taking further internship training. There are also cases of physicians who have completed residency training programs who are now being employed as assistants to licensed physicians in the state.

The committee was informed there are many physicians who have failed to register with Selective Service and because of this failure might escape their military obligation. Selective Service contacts and informs these individuals they must, within a reasonable length of time, register or show proof of having registered. Their failure to comply with this provision of the law makes them liable to prosecution by the Department of Justice. Every male person who is in or who enters the United States, and has received from any school, college, or similar institution of learning, one or more of the degrees of bachelor of medicine, doctor of medicine, doctor of dental surgery, doctor of medical dentistry, doctor of veterinary surgery and doctor of veterinary medicine; is not an exchange visitor or member of any reserve component of the Armed Forces of the United States; who on 16 October 1950 had not attained the fiftieth anniversary of the day of his birth, is required to submit to registration with the Selective Service System as a Special Registrant. Any person entering the United States who is one of the medical, dental or allied specialists listed above, shall present himself for and submit to registration before a local board within the period of five days follow-

ing the date on which he enters the United States.

It was pointed out that with the expiration of the Doctor Draft Law, liability for military service will cease for many physicians as the regular draft law affects men only until they reach their 35th birthday. Quoted below are the present Selective Service regulations showing in what order regular registrants are now selected for induction as enlisted men:

(1) Delinquents who have attained the age of 19 years in the order of their dates of birth with the oldest being selected first.

(2) Volunteers who have not attained the age of 26 years in the sequence in which they have volunteered for induction.

(3) Nonvolunteers who have attained the age of 19 years and have not attained the age of 26 years and who do not have a child or children with whom they maintain a bona fide family relationship in their homes, in the order of their dates of birth with the oldest being selected first.

(4) Nonvolunteers who have attained the age of 19 years and have not attained the age of 26 years and who have a child or children with whom they maintain a bona fide family relationship in their homes, in the order of their dates of birth with the oldest being selected first.

(5) Nonvolunteers who have attained the age of 26 years in the order of their dates of birth with the youngest being selected first.

(6) Nonvolunteers who have attained the age of 18 years and 6 months and who have not attained the age of 19 years in the order of their dates of birth with the oldest being selected first.

At this time Selective Service is calling only those in the first three categories and you will note they are not calling any regular registrant who has a child or children with whom he maintains a bona fide family relationship in his home, or who has exceeded the 26th anniversary of the date of his birth, with the exception of violators of the Act who are delinquents.

This committee does not believe a sufficient number of physicians will be available to fulfill the needs of the Armed Forces unless the draft law affecting all young men in the medical field is drastically rewritten. Under the current Doctor Draft Law deferment is not granted for fatherhood, since doctors are commissioned as officers and receive pay and allowances far higher than the young man who is inducted into service as a regular registrant. A doctor can be deferred for dependency under the present Doctor Draft Law only if it can be proved that his entering service would cause extreme hardship and privation to his dependents.

Selective Service informs us that anyone entering the country who was born before 15 September 1925 need not register under the general provisions of the Universal Military Training and Service Act, as amended. If a man is 26 years of age, or older, at the time of his registration with Selective Service, he is immediately eligible for a V-A classification, meaning his liability for military service has ceased. For a regular registrant to be liable for service until 35 years of age, he must have been in a deferred classification prior to his 26th birthday, which extended his liability. Therefore, any individual entering the country within the next year, who was born before 1931, will, in all probability, never have to serve in the Armed Forces unless he should choose to volunteer for active duty. We believe if the tremendous number of physicians who are graduates of foreign medical schools could be utilized by being made liable up to their 35th birthday, there might be sufficient numbers to meet the needs of the Armed Forces and in this way avoid having a special draft law which would call the older physicians.

The following recommendations were presented to the Council:

1. That recommendations be presented to the American Medical Association and the Federal Government that with the dropping of the Doctor Draft Law adequate legislation be written under the Universal Military Training and Service Act, as amended, to provide sufficient specialists to meet the needs of the Armed Forces — that all physicians under 35 years of age have an obligation to serve in the Armed Forces, including alien doctors who enter the country after their 26th birthday. This would be a more equitable law.

2. That necessary steps be taken to compel the Department of Registration and Education, and the American Hospital Association, to investigate the staffing of hospitals with unlicensed

physicians, so the practice of individuals taking unlimited amounts of residency training before becoming licensed will be stopped. We believe if these individuals are not permitted to remain in these hospitals without licenses, they will become fully licensed.

3. That the cases of physicians holding limited licenses for over two years be brought to the attention of the Department of Registration and Education for the purpose of taking steps to make it mandatory for them to become fully licensed within two years after having received a limited license, or have the limited license revoked.

Earl H. Blair, M. D.
Harold M. Camp, M. D.
Carl F. Steinhoff, M. D.
F. Lee Stone, M. D.

Number of college graduates entering medical practice

During the recent Institute on Evaluation of the Student, held under the auspices of the Association of American Medical Colleges at Colorado Springs, Colorado, in November 1956, some interesting data concerning the number of college graduates entering medical practice were presented by Dale Wolfle of the Association for the Advancement of Science. He pointed out that for the past 10 years the number of all college graduates who entered medical practice was only two per cent.

This is in contrast to the situation of 150 or even 75 years ago; from 1801 to 1880, at least 28 per cent of all college graduates started medical practice. It should be pointed out that from 1821 to 1840, the percentage rose to 35. After 1881, the percentage commenced to decline steadily until only two per cent of college graduates since 1946 are entering into the practice of medicine.

In studying these statistics, we should keep in mind that in the last century, most persons attended college specifically to train themselves for the professions such as medicine, law, and the ministry. More recently the trend has been to obtain college training for almost any walk of life one chooses to enter. Thus we should consider these figures in relation to the present day demand for college graduates by the business world.

Let us consider certain data that concern the estimates of the number of college graduates in future years. It is predicted that in 1965, only eight years from now, there may be 442,000 students graduated from college. This is a conservative estimate; another figure quoted is as high as 513,000. Parenthetically, it may be stated that it is predicted that in 1957 about 321,000 will be graduated from college.

If we assume that two per cent of the students graduating from college in 1965 will enter medical practice, the number would be at least 8,840. If we use the upper estimate, then as many as 10,260 persons might become practicing physicians and surgeons. Actually, the assumption that two per cent of future college graduates ultimately will practice medicine may be erroneous. It might be that because the percentage has decreased steadily since 1880, we should assume that the percentage will go even lower. But it might very well be that two per cent is a basal level, and we should use that figure.

In 1970, only 13 years from now, it is predicted that at least 540,000 students will be graduated from college; while a higher estimate predicts 687,000. Assuming that two per cent of these graduates enter medical practice, we have in the instance of the conservative figure, 10,800 or, in the case of the higher number, 13,740 new physicians in one year, or double the present rate.

These figures are impressive. If we may be allowed to extrapolate the date to estimate the number of medical students at any one time, it would appear that 13 years from now there may be a total of at least 43,200 persons (and perhaps even more than 55,000) studying medicine. These figures appear staggering but they are based upon the best evidence now available.

It is obvious that unless either existing medical schools substantially increase their enrollment, which does not seem likely or feasible, or more medical schools are established, it will be extremely difficult for all qualified young men and women who wish to become physicians to gain acceptance into medical schools. For that matter, due to the expected increase of the total population, there may even be an acute shortage of physicians. In view of these facts, the State of West Virginia is fortunate indeed that it is developing its medical center. *Edward J. Van Liere, M.D., West Virginia Med. J.*

The electrolung

Many children with cerebral palsy are unable to speak properly because they breathe between 60 and 80 times per minute. With such rapid respirations, continuous speech is impossible. The defect can be corrected with a new electrolung that superimposes a proper pattern of breathing and gives the child an opportunity to experience the proper rhythm. Once he learns how to breathe regularly, he has something to aim at on his own. The apparatus is being used at Northwestern University Department of Speech Correction and Audiology. One child with tension athetosis, who was totally inarticulate, developed socially acceptable speech after six weeks of treatment for one-half hour daily. Fourteen cases with this type of cerebral palsy have received electrolung therapy with good results.

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Andy Hall celebrates his 92nd birthday

Dr. Andy Hall of Mt. Vernon, Illinois, celebrated his 92nd birthday, on January 8, 1957. He graduated from Northwestern University Medical School in 1890 and is now on his 67th year of practice. He still maintains daily office hours, beginning at 8 a.m. He still attends medical meetings in many states, most recently the A.M.A. Clinical Session in Seattle, Washington.

Dr. Hall still goes fishing and hunting, and has no trouble in getting his limits in either game or fish. On his last trip to Tennessee he planned to fish two days but caught so many the first day, he was afraid he might not find enough fish lovers to take the entire catch, so he returned home, bemoaning the fact that he would not make another trip to his favorite fishing hole until early spring.

He also procured a license late in the fall to hunt pheasants, and when he returned after one hour with his limit in pheasants, he decided to spend the remainder of the day shooting quail, and again was quite successful.

Dr. Hall spent four years as director of the State Department of Public Health and for more than 20 years was a member of the Council of the Illinois State Medical Society. In 1949 he was selected as the A.M.A.'s "Doctor of the Year," and during the next year he traveled across the nation attending medical meetings and making many fine addresses. He was the first and, to date, the only chairman of the Fifty Year Club of the Illinois State Medical Society. In that capacity, he has presented many dozens of certificates and emblems to physicians who have qualified for membership in the organization.

We will all be glad to greet Dr. Hall in person at the 1957 annual meeting of the State Society when he will again preside at the luncheon meeting of the Fifty Year Club.

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Dr. E. K. Ellis honored by his county society

At the annual Christmas meeting of the Jackson County Medical Society, Dr. E. K. Ellis, retiring president was honored for his many years of service to his county medical society. A citation was presented to Dr. Ellis for his continuous service to the society as an officer from 1920 to 1956.

Dr. Ellis acted as secretary-treasurer of the society from 1920 to 1954, was elected president-elect in 1955 and acted as president during the past year. The society extended its greetings, best wishes and thanks to Dr. Ellis for his helpful and meritorious service over a period of 37 years.

For continuous service as an officer of a county medical society, this is indeed a long period of time, and your editors would like to receive information from other societies where a member has given services over a similar period of time.

We know of a few instances where a physician has been an officer of his component society over a period of at least fifty years, but not actually in continuous service.

We, too, offer our thanks and best wishes to Dr. E. K. Ellis for his fine services to a component society, and the many communications we have received from him in his long tenure of office as secretary.

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MEDICAL ECONOMICS

Medical research

The years since World War II have witnessed a revolution in medical research in the United States. The most significant aspects of this revolution relate to the substance of medical science itself — but the most interesting sideline is the volume of money now pinpointed towards research, as well as the source of this support.

Dr. James Shannon, Director of the National Institute of Health, United States Public Health Service, has recently presented a summary of this aspect of medical research. (Science 124: 1185-1190; Dec. 14, 1956)

Fifteen years ago, $40 million per year was spent on medical research. As of today, the sum total is $240 million per year. Where does this money come from?

Prior to 1940 the federal contribution was some $3 million, representing 7% of the total. By 1944 the total had reached $10 million per year, some 16% of the total amount spent on research.

The year 1947 may be considered the first year of the postwar era in medical research. Our government gave $28 million for this purpose, (32% of the total). By 1955 the total support of medical research had risen to $240 million, with the federal government's share being $113 million, or more than 40%.

During the years since World War II the larger philanthropies and health agencies have greatly expanded their support of medical research.

While the contribution of the well endowed foundations has declined, it is very significant that the increases in government support have not reduced the contributions from philanthropy, endowment, or private industry. In fact, private support for medical research has increased in the postwar period, although not in proportion to the expansion of federal aid.

Somewhat more than $40 out of every $100 for medical research is expended in medical schools and universities. These institutions spent about $100 million in 1955 for medical research. $75 million was spent in medical schools. Less than $20 million of the total of about $100 million expended in these institutions came from endowment. About 30 million came from all kinds of philanthropy, individual gifts, private health associations and foundations. Finally, the federal government contributed $55 million in 1955 toward research.

It is abundantly evident from these figures that academic research is largely dependent on sources of support which are not controlled by the institutions themselves. It seems quite probable that endowment income will not rise in the foreseeable future. One may question whether support from private philanthropy will rise markedly. It is highly probable that the two major sources of expanded support for medical research in the future will be corporate giving and federal funds.

The implications of this are quite obvious to

anyone interested in the proper approach to research.

Research in itself must possess a freedom that is out of proportion to all other freedoms. The investigator must have the privilege of working at his own speed; of continuing his search for the truth without being hampered by outside sources. He must be able to proceed on his own and must have the privilege of attacking a new idea as it develops.

It is well said, that "he who controls the purse strings has the power." What will the effect of government and corporate giving have — not only on the investigator but the type of investigation he conducts? We must recognize that the research grant and training programs have changed, are changing and will change in the future. Just as productive science is dynamic, so is a productive society and economy. Responsible administrators of both corporate and federal research programs have a very real and significant obligation to act so that their activities increase the productivity of research and the availability of training.

Administrators must act on the basis of sound, widely representative advice. Never in the history of medical science and medical education has it been so important that close, sympathetic understanding be sustained between private research groups, universities and medical schools, industrial research groups and federal agencies. The extension of federal aid to medical research and related training, over the past decade, has created a situation in which the actions taken federally are of such significance that wide participation in the decision making process is essential.

Dr. Shannon has certainly done us a tremendous favour in calling this problem to our attention.

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Blue Shield service contracts

Service type contracts are offered by 50 U.S. Blue Shield plans.

The Buffalo, N. Y. Blue Shield organization became a service program starting Nov. 1, 1956. This change from indemnity to service was the decision of the Buffalo Participating Physicians, who voted to accept the proposed change. Their vote was described as overwhelmingly in favor of the service program.

We in Illinois had better start thinking about this problem. What are your ideas?

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We live longer

The JAMA of Dec. 15, 1956 says that Doctors outlive other men. It is comforting to know this. In 1950 there were 204,450 physicians in the United States. In 1949 to 1951 there were 10,738 deaths. This was only 93% of the number expected based on the figures for the white male population in general.

In fact, life expectancy for physicians was better at almost every age level than it was for other men. The only group of physicians that had higher death rates than the rest of the male, non-physician population was the age group 60 to 69.

Heart disease and diabetes took their toll at this age level.

Well, to this worn out obstetrician these facts are quite comforting. All he has to do from now on is to conserve his coronaries, be on the lookout for cancer, and check his urine daily.

Lovely thoughts.

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Social and economic aspects of old age

Mr. Clark Tibbets, of the Department of Health, Education and Welfare, presents an interesting discussion of the social and economic aspects of old age, in the American Geriatric Journal, (4:871-876, Dec. 1956).

We all recognize that more people are living longer. We all recognize the medical aspects of this problem; but many of us are unaware of the social and economic problems relative to this group of people.

At the present time we tend to think of our geriatric patients as non-productive, semi-invalid and retired people. Since we hope that the life span will continue to lengthen and that our medical research will lead to a fuller life for such individuals, we had better make plans to help these people on an economic level.

Certainly physicians trained in geriatrics must be leaders in developing new ideas on this subject. It would be well to read this thought provoking article.

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ILLINOIS DEPARTMENT OF PUBLIC HEALTH



Roland R. Cross, M.D., Director

Epidemic disease situation

Since this is the first meeting of a new year, a little stock-taking as to the epidemic disease situation may be in order. 1956 was the ninth successive year without any case of smallpox having been reported in Illinois. This contrasts with 31,304 cases reported in this State during the 9 years beginning with 1920. Last year there were 10 cases of diphtheria reported in Illinois and 289 cases during the past 9 years. This contrasts with 98,996 cases of diphtheria reported in the State during the 9 years beginning with 1920. Last year, 54 cases of typhoid fever were reported in Illinois with a total of 572 during the past 9 years. This contrasts with 16,747 reported during the 9 years beginning with 1920.

These statistics reflect a record of outstanding credit to the practice of preventive medicine. A sharp epidemic flare-up of diphtheria in Indiana late last summer and more recently in Michigan demonstrated that this disease is by no means abolished. Only diligence in maintaining a high level of immunity in the population will maintain control over it.

Typhoid fever is more difficult to manage than is diphtheria. Detection and continuous surveillance of carriers and maintaining a high level of sanitation, especially of milk and water supplies, are required to prevent an upsurge of this disease. The high mobility of the population and the trend toward urban concentration complicate this already complex problem. Detailed epidemiological study of every case and a continual vigorous program of sanitation are necessary to keep typhoid fever under control.

Complete freedom from smallpox like the near-freedom from diphtheria illustrates the great benefits which accrue from persistent and successful efforts at vaccination throughout the population. It appears now that similar results may be expected through an intensive and sustained vaccination campaign against polio.

Among other epidemic diseases, measles and chicken pox were widely prevalent during 1956. Except for the outbreak of polio in Chicago there was no substantial change in the incidence of other reportable diseases.

Advisory board on necropsy service

The first meeting of the Advisory Board on Necropsy Service was held at the Leland Hotel in Springfield on Friday, January 18. At that time the Board organized and then discussed legislative matters of interest to it.

Only 7 of the 9 members provided by the law have been appointed. These 7 were appointed on October 29, 1956. Since it was already late for the consideration of legislation which may come before the 70th General Assembly, it seemed wise to call the meeting without waiting any longer for the appointment of the two additional members.

Reported to the Council of the Illinois State Medical Society, Jan. 13, 1957.

Dr. David O. Holman, Springfield

Dr. Edwin F. Hirsch, Chicago

Dr. Jacob E. Reisch, Springfield

Rep. Bernard McDevitt, Professor of Medical Law, Loyola Medical College, Chicago

Mr. Clark Davis, Coroner of Grundy County, Morris

Mr. Joseph Hallett, Coroner of McLean County, Bloomington

Mr. Don Wikoff, Coroner of Champaign County, Champaign.

Yet to be appointed are two members with "interests and abilities in the field of forensic medicine" who are neither licensed physicians nor coroners.

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Concepts on research

During the 25 years that I have been associated with medical research, I have either learned or have had confirmed, two or three concepts. First, in medical research, the bottleneck is not lack of equipment or plant but lack of well trained, imaginative, and gifted investigators. You may have the finest equipment on earth, but it is still the individual investigator that is the important factor. We need more young people going into research in all fields than we now have in this country. For instance, in Russia, there are about 250,000 students entering college to study for the various scientific fields each year, and these are a selection from approximately 2,500,000 applicants. In this country we have approximately 60,000, or one-quarter this number of students entering college to study science each year, and this includes the medical sciences. Through the years the quality and quantity of laboratories and equipment have shown great improvement.

The second lesson is partly related to the first, that is, the future of medical research and therapy is increasingly tied up with these basic sciences, physics, chemistry, and mathematics, and medical education must be adjusted to these needs. We are lagging behind several countries in this respect, particularly Sweden and England, and probably Russia. It is time for us to establish in our medical schools professors of chemistry and biophysics with rank equal to that of the clinical professors and to see that the physical sciences become an integral part of the medical curriculum.

The third point I want to make, something I have always known, is that it is dangerous for an individual or a university to exert strong control over the direction of research activity. Freedom of the individual is a strong tradition in this country, and in no place is individual freedom more important than in research. It was not so long ago that I served on a research committee, and one member recommended that no research project be submitted in application for support, in or outside the university, unless the committee agreed it was a worth while study and approved the proposal. Fortunately, we were able to defeat this motion since the committee as a whole saw that it would take the heart out of any university to put this power into the hands of a committee. One large pharmaceutical company I know considers it worth while if one per cent of its research activity pays dividends in the form of an important new contribution to medicine. One cannot predict whether a piece of research is going to pan out or not. Accidental by-products of research sometimes are important, and I have seen many examples of them. *John H. Lawrence, M.D. Some Studies of Function and Structure in Medicine. Quart. Bull. Northwestern Univ. M. School. Fall* 1956.

THE P. R. PAGE

Edward A. Uzemack, Director of Public Relations

DID you ever wonder what it takes to be an ideal physician? Dr. P. H. Woutat of Grand Forks, North Dakota did and came up with a remarkable analysis of such an individual.

In his presidential address at a recent meeting of the North Central Medical Conference, Dr. Woutat painted an impressive verbal picture of the ideal M.D. He said:

"The ideal physician must, of course, be of fine and scholarly appearance, with great intellectual capacity, of faultless personal habits, and inspire the confidence of his patients and the respect of all others.

"He must be active in community affairs, taking his full part in Chamber of Commerce and service club functions, serve on and advise municipal and other governmental bodies as called upon, be active in local and state political affairs, be a good church worker and attend church frequently.

"He must be available on short notice for papers to local PTA and church groups, service and business girls' clubs, and all other groups and organizations interested in obtaining reliable information on medical subjects. He must, of course, take an active part in the various youth programs of the community.

"He must work on and contribute liberally and cheerfully to fund-raising campaigns for new hospitals, YM and YWCA's, old peoples' homes and nursing homes, give liberal support to the church and community chest, and help defray the deficit of the local ball club.

"He must be active in his local and state medical societies, attend meetings regularly, and accept officership and committee assignments eagerly and perform his duties quickly and with great tact and diplomacy.

"He must be faithful in attendance at hospital staff meetings, be ready to give carefully prepared scientific papers, serve on hospital committees cheerfully and efficiently, keep his hospital records complete in all details, and be prompt with carefully prepared lectures to the student nurses.

"He must be a good family man with a gracious and tactful wife who abhors mink coats and other vulgar extravagances, and must spend lots of time at home with his children.

"But above all this, he must never fail to give his patients the finest possible medical service, keeping abreast of medical progress by reading, attendance at medical meetings, and taking frequent postgraduate courses. He must be a tireless worker and improve his public relations by spending adequate time with his patients, answering urgent calls promptly, day or night, and by not keeping his patients waiting. This must all most certainly be done for what has been vaguely defined as a reasonable fee."

(Ed. Note — That's *some* doctor, Doctor!)

Why newsmen often grouse —

Jack Mabley, one of the more readable columnists for the Chicago Daily News, recently made an enlightening observation on one of the principal characteristics of newspapermen.

"The journalism books would call it a healthy curiosity," he wrote. "I'd call it a natural suspicion, a skepticism that comes from years of unrelieved exposure to windbags and phonies and crooks."

X-ray pioneer hailed as medical hero —

At least twice within recent months, Chicago newspapers have brought out of relative obscurity the remarkable story of Dr. William H. Grubbe, now 81, who is credited with being the first to use x-rays as a healing agent. Only four weeks after Wilhelm C. Roentgen announced the discovery of x-rays, Dr. Grubbe treated a Chicago woman suffering from breast cancer.

Since nothing was known about the dangerous cumulative effects of repeated exposure to x-rays, the Chicago physician incurred burns which have caused him to undergo more than 90 operations.

His upper lip is largely excised, and so is most of his nose and much of his face. His left hand is gone and there are only two fingers on his right hand. As tissue continues to die, he will be subjected to further operations.

Nevertheless, Dr. Grubbe remains philosophical. "It had to be someone," he says.

Radio and television materials —

County medical societies in television areas will have available in the near future a series of A.M.A. — produced animated filmed cartoons which carry 22-second health messages. The TV film will end with the line: "This is a health message from Blank County Medical Society and the American Medical Association."

Familiar nursery rhyme characters like "Humpty Dumpty" and "Jack and Jill" will be used to bring the latest word on such subjects as safety, first aid, food preservation, cold prevention and long life. If your society would be interested in offering such a film series to a local TV station, please write to the Director of Public Relations, Illinois State Medical Society, 185 N. Wabash Ave., Chicago 1, Illinois.

Modern surgery will be highlighted in a new, 13-program series of radio transcriptions which the A.M.A. is preparing for use over local stations. The series will be available for placement by county medical societies about March 1. It will enable the public to hear on-the-spot descriptions of actual surgical procedures.

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New sound film available

A simplified approach to complete vaginal repair is demonstrated in a new color film prepared by Drs. Stanley F. Rogers, Jack Moore and Warren Jacobs of the department of obstetrics and gynecology, Baylor University College of Medicine and Methodist Hospital, Houston.

The 20-minute long, 16 mm. sound film was prepared through a grant from Eaton Laboratories. It is available for showing to medical groups on request to the medical director, Eaton Laboratories, Norwich, N.Y.

While it is based on procedures developed and reported by many authors, the technic demonstrated by Dr. Rogers and his colleagues has been simplified, is attended by little blood loss and can be performed in a relatively short time.

CORRESPONDENCE



Chicago Medical Society's Annual Clinical Conference

The Annual Clinical Conference of the Chicago Medical Society will be held at the Palmer House, Chicago, March 5-8, 1957. Four full days of scientific papers have been scheduled, covering many subjects of general interest to all members of the medical profession. More than 30 guest speakers from outside the Chicago metropolitan area have been invited to participate in these presentations, in addition to a number from Chicago.

The usual large number of commercial exhibits will be displayed in the exhibition hall of the Palmer House, and there will be many fine scientific exhibits. There will be daily teaching demonstrations and medical color telecasts.

From 12:00 to 1:30 p.m. each day, there will be luncheons and round table discussions which have been so popular at previous Clinical Conferences. The annual dinner is scheduled for 7:00 p.m. Wednesday in the Grand Ball Room of the Palmer House, followed by entertainment, and dancing.

There will be no registration fee for members of the Chicago Medical Society and a minimal charge of $5.00 will be made to other registrants. The Woman's Auxiliary to the Chicago Medical Society will be on hand to welcome visiting ladies, and various types of activities are being arranged for them.

Dr. Eugene T. McEnery is general chairman of the Executive Committee which is composed of a considerable number of prominent members of the Chicago Medical Society.

The complete program for this fine conference may be procured by writing to the Secretary of the Chicago Medical Society, 86 East Randolph Street, Chicago 1, Illinois.

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Women's activities at the Clinical Conference

A cordial invitation is extended to all wives of doctors who plan to attend the Chicago Medical Society's Clinical Conference at the Palmer House in Chicago, March 5-8 inclusive.

The following is a partial list of what the Woman's Auxiliary to the Chicago Medical Society has planned for you when you accompany your husband to the Conference:

Tuesday, March 5 - 9:00 AM to 4:00 PM registration in Hospitality Room which will be open during these hours each day serving refreshments, giving you an opportunity to greet your old friends and make new ones. Card tables will be set up. Tickets for television and radio shows will be available.

12:30 PM "Fashion Plates And Platters" — beautiful spring fashion show and luncheon in Grand Ballroom of Sheraton Hotel. Tickets are limited. Reservations close Friday, March 1. $5.00 each from Mrs. Alfred Pagano, 241 Keystone Avenue, River Forest, Ill.

Wednesday, March 6 — 9:00 AM to 4:00 PM

registration in Hospitality Room. 2:00 to 4:00 P.M. one and one-half hour tour of Chicago Tribune newspaper plant.

Thursday, March 7- 9:00 AM to 4:00 PM registration in Hospitality Room.
Afternoon tour of Polish Roman Catholic Museum.

Friday, March 8 - 9 AM to noon, Registration in Hospitality Room which will be open until 2 PM.

The Committee, headed by Mrs. Richard Westland, chairman, Women's Activities of Clinical Conference and Mrs. Matthew Uznanski, our president, are most anxious to make your visit to Chicago an enjoyable one and we feel sure if you avail yourself of the above entertainment you will get to know us better and know our Chicago, too!

Mrs. Joseph Shanks,
Press & Publicity Chairman
Woman's Auxiliary to the
Chicago Medical Society.

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Clinics for crippled children listed for March

Twenty three clinics for Illinois' physically handicapped children have been scheduled for March by the University of Illinois, Division of Services for Crippled Children. The Division will count 17 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing service. There will be 3 special clinics for children with cardiac conditions, 1 for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in co-operation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The March clinics are:

March 6 - Carmi, Carmi Township Hospital

March 6 - Centralia, Recreation Center

March 6 - Hinsdale, Hinsdale Sanitarium

March 6 - Jacksonville, Passavant Hospital

March 6 - Rock Island (Cerebral Palsy), Foss Home, 3808 - 8th Avenue

March 7 - Sterling, High School Field House

March 8 - Chicago Heights [Cardiac], St. James Hospital

March 12 - East St. Louis, St. Mary's Hospital

March 12 - Peoria, Children's Hospital (St. Francis)

March 13 - Joliet, Will County T. B. Sanitarium

March 14 - Sparta, Sparta Community Hospital

March 14 - Springfield, St. John's Hospital

March 19 - Alton, Memorial Hospital

March 19 - Shelbyville, Methodist Church

March 20 - Elmhurst [Cardiac], Memorial Hospital of DuPage Co.

March 20 - Evergreen Park, Little Company of Mary Hospital

March 21 - Rockford, St. Anthony's Hospital

March 22 - Chicago Heights [Cardiac], St. James Hospital

March 26 - Effingham (Rheumatic Fever), St. Anthony Hospital

March 26 - Peoria, Children's Hospital (St. Francis)

March 27 - Aurora, Copley Memorial Hospital

March 27 - Springfield (Cerebral Palsy), Memorial Hospital

March 28 - Decatur, Decatur-Macon County Hospital

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Chicagoans to speak at International College of Surgeons meeting in Mexico City

Eight Chicagoans will present scientific papers at the 10th biennial International Scientific Congress of the International College of Surgeons in Mexico City, Feb. 24-28.

The meeting will be attended by surgeons from all sections of the free world, according to Dr. Max Thorek, Chicago, secretary general and founder of the College. More than 300 from the United States are expected to participate.

Those surgeons from Chicago who will deliver scientific papers, and their subjects are:

Ross T. McIntire, executive director of the International College of Surgeons: "Research in Newer Methods of the Preservation of Red Blood Cells."

Otto L. Bettag, director of the Illinois De-

partment of Public Welfare: "Thoracic Surgery in the Mentally Ill."

Edward L. Compere, professor and chairman of the department of orthopedic surgery, Northwestern University Medical School: "Fractures and Dislocations of the Wrist."

Horace E. Turner, clinical assistant professor of orthopedic surgery, University of Illinois College of Medicine: "Useful Application of the Intermedullary Nail for Conditions Other Than Fractures."

Carlo Scuderi, associate professor of orthopedic surgery, University of Illinois College of Medicine; "Stem Prosthesis in Hip Surgery; the Indications and End Results."

Claude N. Lambert, associate professor of orthopedic surgery, University of Illinois College of Medicine: "Use of Upper Extremity Prosthesis in Juvenile Amputees." (Movie.)

Emanuel M. Skolnik, assistant professor of otolaryngology, University of Illinois College of Medicine: "Congenital Cysts and Fistulae of the Head and Neck."

Peter A. Rosi, associate professor of surgery, Northwestern University Medical School: "Management of Bleeding Peptic Ulcer."

The congress is being held in Mexico City at the invitation of His Excellency, Don Adolfo Ruiz Cortines, President of Mexico. It will combine an excellent scientific program by outstanding surgeons of the world with an opportunity to enjoy the show places of Mexico.

Four days will be devoted to the scientific program, to be presented at the University of Mexico. This will cover all phases of surgery. Blocks of rooms have been set aside in Mexico City's finest hotels for those attending. Social functions have been scheduled. For those who wish to see something of the country, two post-congress tours have been arranged.

In view of the large attendance which is expected, and the shortness of time, reservations should be made at once. To simplify the making of arrangements, the International Travel Service, Inc., Palmer House, Chicago 3, Ill., has been chosen to handle registrations for the congress, hotel reservations and travel.

Inquiries for further information should be directed to the International Travel Service, Inc.

Clinical Reviews

On April 1, 2 and 3 the Mayo Clinic and the Mayo Foundation for Medical Education and Research, will again present a three day program of lectures, discussions and demonstrations called Clinical Reviews.

The meeting covers problems of current interest in general medicine and surgery, and members of the American Academy of General Practice who attend, may obtain up to 21 hours Category 1 Credit.

Since registration must be limited, physicians who wish to attend should communicate at once with Mr. R. C. Roesler of Mayo Clinic, Rochester, Minnesota. There are no fees for this program.

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Inter-American Medical Convention

The Second Inter-American Medical Convention will convene at the Hotel El Panama, Panama City, Republic of Panama, April 3, 4 and 5th, 1957, under the sponsorship of the Medical Society of the Isthmian Canal Zone, a chapter of the American Medical Association since 1906. Colonel Charles O. Bruce, MC, USA, Chief Health Officer of the Panama Canal Company and President of the Medical Society, will act as keynote speaker at the invocation ceremonies, which will include addresses by the President of the Republic of Panama and by the Governor of the Panama Canal Zone.

Registration will take place at the Hotel El Panama at 9:00 a.m. April 2nd, the registration fee being $5.00. The program will be wide in scope, and on the order of a state medical convention in the United States. Speakers will be from North and South America, and all papers will be translated into both English and Spanish. For further information write to Dr. William T. Bailey, Chairman of the Convention Executive Committee.

Following invocation ceremonies, a lecture on "Surgery in Carcinoma of the Lung" will be given by Dr. William F. Reinhoff Jr., followed by a paper on "Surgery of Pulmonary Lesions Other Than Cancer" by Dr. Hawley H. Seiler.

On Wednesday afternoon Dr. Chester W. Emmons will discuss the problem of "Histoplasmosis," Dr. Irving J. Selikoff "Tuberculosis —

Therapy and Trends," and Dr. R. B. Turnbull "Post-Operative Infections."

Thursday morning will be devoted to a symposium on "Mass Casualty Management" by a team of research workers in this field from the U.S. Army Medical Centers at Walter Reed Hospital and Brooke Army Hospital. Colonel Joseph R. Schaeffer, MC, USA; Colonel James E. Graham, MC, USA; and Lieutenant Colonel Robert Pillsbury, MC, USA.

Thursday afternoon has been planned for a Tropical Medicine Panel, and will include a paper on "Amebiasis" by Dr. William A. Sodeman, a lecture on "Leishmaniasis" by Dr. Carl Johnson, and Colonel Victor Hirshman, MC, USA will discuss the problem of "Moniliasis."

On Friday morning, Dr. Joseph W. Kelso will discuss the problem of "Surgical Treatment of Cancer of the Uterus," to be followed by the radiologist's views as given by Dr. J.A. DelRegato in his paper, "Status of Radiation Therapy in the treatment of Cancer of the Uterus." Dr. Edward Shanbrom will then read his paper on "Newer Aspects in Diagnosis and Treatment of Leukemia and Lymphoma."

On Friday afternoon, Dr. Frank Stelling will explain the "Orthopedic Management of the Polio Patient." Dr. Meredith F. Campbell will talk on "Obstructive Uropathies in Childhood" and Dr. Harold W. Brown will give his paper on "Visceral Larval Migrans."

In addition to the scientific papers, a full round of entertainment is planned for families who accompany the delegates. A buffet dinner for all the delegates and their families will be held in the patio of the Hotel El Panama on Wednesday evening. A luncheon for the visiting wives will be sponsored by the Doctor's Wives Club of the Republic of Panama at the Union Club at noon on Thursday, followed by conducted shopping and sightseeing tours by the same ladies through the exotic oriental shopping centers of Panama City. Sectional dinners of the various specialties will serve as a get together for like minds on Thursday evening, and this will be followed by a fashion parade in the El Panama patio by the Doctor's Wives Club of the Panama Canal Zone. Trips on ships transiting the Canal, deep sea fishing in the Bay of Panama, trips into the interior of Panama and many other such diversions are available.

Symposium to discuss "Fats in Human Nutrition"

"Fats in Human Nutrition" will be discussed in a symposium to be held March 15 in the Louisiana State University auditorium, New Orleans, under the sponsorship of the American Medical Association's Council on Foods and Nutrition.

Co-operating in presenting the symposium will be the Orleans Parish Medical Society, the New Orleans Graduate Medical Assembly, the School of Medicine of Louisiana State University, and the Tulane University School of Nutrition.

Speakers will include outstanding men in nutrition, biochemistry, pediatrics, heart disease, and other allied fields.

Special emphasis will be on fats, cholesterol, and atherosclerosis, according to Dr. Philip L. White, secretary of the Council on Foods and Nutrition. The meeting is especially planned for general practitioners and other physicians, nutritionists, educators, home economists, and others interested in nutrition.

The American Academy of General Practice is offering six hours of credit in category one to members of the Academy who attend the symposium.

Those interested in attending may get further information by writing the Council on Foods and Nutrition, American Medical Association, 535 North Dearborn, Chicago 10, Illinois.

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Care for the unwed mother

The Chicago Foundlings Home offers residential and nursery care, as well as adoption service for the unwed mother. It is the oldest and the only co-operative home of its kind in this part of the country, where homemaking is offered in lieu of a fee. It was founded in 1871 as a hospital for abandoned babies and mothers by Dr. George E. Shipman, a practicing physician in Chicago in the middle 1800s, who was appalled by the absence of any kind of care for foundlings at that time.

Upon recommendation of a physician, the Home will accept expectant mothers at any stage of their pregnancy. Medical care can be arranged with neighboring clinics in accordance with the mother's desire and financial situation.

A new Home is being planned in the Medical Center, in the near future, which will be located at 1750 West Polk Street.

Medical program combines with South Dakota pheasant hunting

The Hunter's Fall Medical Meeting sponsored by the South Dakota State Medical Association will be held at Mitchell, South Dakota during the first five days of pheasant hunting season in October, 1957.

The program is set up for out-of-state doctors and will feature morning scientific sessions, afternoon hunting and evening scientific and social sessions.

The registration fee is set at $100.00 which will cover the out-of-state hunters license, hunting guides, reserved hunting areas, several social events, and the scientific program. Motel and hotel space has been reserved, but registration is limited to the available housing.

The affair is not stag, but wives who hunt must pay the full registration fee and those not hunting, three-fourths of it. (This is necessitated by the tight housing situation.)

For details and reservations write to Mr. John C. Foster, Executive Secretary, South Dakota Medical Association, 300 First National Bank Bldg., Sioux Falls, South Dakota.

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No cause for alarm

Medical and dental students who are also Reservists have recently received a Department of the Army notice titled "Period of Alert for Active Duty for Members of the Army Reserve."

According to Col. James H. Kidder, Special Assistant for Reserve Forces to the Army Surgeon General, recipients of the notices should not be alarmed.

Under Section 233, Public Law 476, Armed Forces Reserve Act of 1952, as amended, members of the Ready Reserve are subject to involuntary order to active duty either in time of war or proclaimed national emergency. Since the nature of a national emergency, particularly in view of the overall world situation, cannot be predicted, each Ready Reservist should have his personal affairs in order, as he may be ordered to active duty in less time than the intended 30 day alert.

Medical and dental students, who also are Ready Reservists, are being reminded of the law as a routine measure and in no way should the action be construed as directly connected with any single international incident.

The Department of the Army policy as to delays for those being ordered into active military service is contained in Army Regulations 135-230 and in substance reflects the following:

"In an emergency, sound reasons may exist why some members of the Reserve components may be delayed temporarily in reporting for active military service. Responsible commanders decide each case based upon its merits. Full consideration of the needs of the service, of the individual, and of the national interest will govern."

"Sound reasoning" requires that medical and dental students be retained in their educational programs to the maximum duration possible, as determined by the extent of any concurrent situation. The value of such individuals not only to the military but also to the nation is greatly enhanced with the completion of each additional phase of their professional training.

The Army intends that medical and dental students who are in the Ready Reserve while enrolled in a graduate course or professional school will continue to be granted delays or renewals consistent with the above policy. This will also include those pursuing full time research in a technical or scientific field in which the Department of the Army has an interest.

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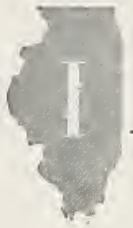
AMA approval announced for Army's general practice residency

Approval of the two-year Residency Program in General Practice at the U.S. Army Hospital, Fort Knox, Ky., has been given by the Council on Medical Education, American Medical Association according to information received by the Education and Training Division, Office of the Surgeon General of the Army.

This is the only residency program of general practice conducted by the Army Medical Service and has sixteen participants. The first year of the program is devoted to medicine and medical sub-specialties, including six months in pediatrics; the second, to surgery and surgical subspecialties, including six months in gynecology and obstetrics.

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AT THE EDITOR'S DESK



NEW drugs are being reported at a fabulous rate. Percodan is one of the latest analgesics; it is weaker than morphine but relieves pain faster and more effectively than codeine. Rolicton tablets are Searle's debut into the oral nonmercurial diuretic field. This product is indicated in congestive heart failure, ascites, edema of hepatic cirrhosis, premenstrual tension, nephrosis, sodium retention, glomerulonephritis, and toxemia of pregnancy.

Gantrimycin is Hoffman-La Roche's new double-spectrum antibacterial which provides Gantrisin plus oleandomycin. The latter is a new antibiotic that is active against gram-positive bacteria. Upjohn also has a new combination antibacterial agent, Alba-Penicillin. It contains penicillin plus Albamycin, a new antibiotic for use against bacteria that have developed resistance to other chemotherapeutic agents.

Pfizer's new chemical form of hydrocortisone is being incorporated into an ointment called Magnacort. It has been tested on more than 500 patients with a wide variety of dermatoses. Relief occurred in 89 per cent. Neo-Magnacort is the same product, with neomycin added. It is recommended for relief of skin inflammations caused by infection or with infection as a complication. Vaseline Lip-Ice is the first lip pomade to contain protective silicones.

New uses for old drugs continue to make press releases. The Mayo Clinic, for example, recently reported that aspirin is the best agent for relief of migraine attacks in children. When the attack starts, it must be administered in sizable dosage, such as one grain per year of age. Aralen (chloroquine) is the latest remedy for creeping eruption. This preparation has obvious advantages over cauterization, freezing, or excision of the active lesions. Isonicotinic acid hydrazide has been used successfully in coccidiodomycosis.

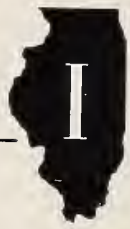
Lederle Laboratories are continuing to experiment with an attenuated live virus poliomyelitis vaccine. The substance has been used for six years on 600 persons varying in age from 5 days to 50 years, with no untoward reactions. The only conclusion reached is that encouraging progress is being made.

Diaphelic is a new name for an old method of immunization — via the nipple. Coffee is not completely devoid of vitamins. Twelve cups a day are said to contain the daily niacin requirements. British physicians are asking for a 25 per cent increase in service pay. The average general practitioner receives approximately $6,221.60 from all sources before taxes. Good luck. We hope they get the increment.

The Veterans Administration reports it has reduced the need for electric and insulin shock therapy for mental illness by an estimated 90 per cent through the use of the tranquilizing drugs. The Veterans Administration Research Hospital in Chicago announces a radioactive cobalt bomb that emits radiations equal to those given off by $30 million of radium. The ma-

(*Continued on page* 114)

NEWS of the STATE



ADAMS

Officers for 1957—Dr. Alfred S. Ash of Mendon has assumed office as president of the Adams County Medical Society, and Dr. Guy L. Tourney of Quincy has been named president-elect. Other officers chosen at the society's annual business meeting in December were. Drs. Julius P. Schoenebaum, first vice-president; Charles E. Richards, second vice-president; Robert C. Murphy, secretary; Harold Swanberg, treasurer; W. M. Libmann, account officer; W. U. McReynolds, editor; Hilliard M. Shair, editor; Carl W. Hagler, historian; Walter M. Whitaker, delegate; Robert W. Taylor, councilor and E. H. Keys, Jr., censor.

A dinner-dance was held by the society on January 25 at the Quincy Elk's Club.

COLES-CUMBERLAND

Dr. Alexander Assumes Duties—Dr. John R. Alexander of Charleston has taken up the reins of the Coles-Cumberland County Medical Societies as president for 1957.

COOK

$600,000 Grant for Fever Studies—A gift of $600,000 to Northwestern University for the study of rheumatic fever and related diseases has been made by a former attorney, Samuel Sackett of Evanston, Illinois. Dr. Roscoe Miller, president of the university, said he believes that this is the largest single grant made by an individual for such research. Sackett has been engaged in the development of oil properties in this country and Canada since the 1930s. In 1954 he established a $500,000 foundation to support studies in the cause and cure of rheumatic fever. The work was financed by the income from the fund. In his latest action, Sackett turned over the principal of that appropriation to Northwestern and added another $100,000.

Faculty Appointments at Chicago Medical School—Four faculty appointments have recently been made at the Chicago Medical School. They are Dr. Franklin P. Friedman, clinical assistant in surgery; Dr. Rhea Hilkevitch, clinical associate in psychology; Dr. Abraham J. Simon, associate in psychiatry, and Dr. Milton Miller, clinical assistant in medicine.

Heart Talks in Mexico City—Dr. Aldo A. Luisada, director of the cardiology division at Chicago Medical School, will give four lectures before the National Institute of Cardiology in Mexico City, February 18 to March 1. He will speak on recent progress in phonocardiography, evaluation of mitral valve defects by left heart catheterization, electrokymography in mitral and aortic valvular diseases, and the mechanism and treatment of acute pulmonary edema.

Teaching and Research Fund—A gift of $20,000 from Mr. and Mrs. David M. Copland of Chicago recently went to the Chicago Medical School to establish the David Copland Special Teaching and Research Fund. Mr. Copland is a retired executive of the General American Transportation Company.

Discuss New Workmen's Law—Dr. Joseph H. Chivers and Atty. John Fox discussed the proposed revision of the workmen's compensation act before a meeting of the Chicago Society of Industrial Medicine and Surgery at Chicago's Palmer House in January. They presented details of legislation sponsored by the Illinois State Medical Society, entitled the "Workmen's Compensation and Rehabilitation Act." Dr. Chivers is a member of the ISMS Committee on Industrial Health and Mr. Fox is a member of the Workmen's Compensation Committee of the Illinois State Chamber of Commerce.

Society of Medical History—Talks on "The History of Hemophilia in the Royal Family" and "The

Seat of the Soul" were presented in January at a meeting of the Society of Medical History of Chicago. Dr. Carroll L. Birch, professor of medicine at the University of Illinois, discussed the "bleeders," and Dr. Percival Bailey, director of the State Psychopathic Institute, delved into the secrets of the soul.

Borovsky Elected Chief of Staff—Dr. Maxwell P. Borovsky of Chicago has been named chief of staff of Cook County Children's Hospital. Professor of pediatrics and chairman of the Department of Pediatrics at Chicago Medical School, Dr. Borovsky is a graduate of the University of Chicago and holder of an M.D. degree from the Rush Medical College. He did postgraduate work in Vienna and Berlin and is a former faculty member of the University of Illinois College of Medicine. His contributions to medical literature in his field are extensive, and he is a past president of the Chicago Pediatrics Society.

Problems of Teenagers—Dr. Frederick H. Allen, director of the Philadelphia Child Guidance Clinic and president of the American Academy of Child Psychiatry, discussed the emotional problems of teenagers at the North Shore Health Resort, Winnetka, Illinois on February 6. His lecture was the fifth in the private psychiatric hospital's seventh annual series on "The Medical Practitioner's Contributions Toward Healthy Emotional Development."

Chicago Physicians Return from Abroad—Dr. William E. Adams, professor of surgery at the University of Chicago, returned from Europe in December after spending several months in Scotland as guest professor of surgery at the University of Glasgow. He also participated in medical congresses in Germany, Switzerland and Wales and gave lectures in Aberdeen, Edinburgh and Madrid. Last November he was made an honorary professor of surgery at the University of Madrid. Another Chicago physician, Dr. Huberta M. Livingstone, lectured on anesthesia at the University of Glasgow in September.

Joint Meeting on Children's Chest Diseases—The Chicago Pediatric Society held a joint meeting with the Illinois Chapter of the American College of Chest Psysicians at Children's Memorial Hospital in December. Speakers on the scientific panel were Drs. Eugene T. McEnery, J. Thomas Graysston, John J. Procknow, Alfred D. Biggs and I. E. Schapiro. They covered respectively the following subjects: Respiratory Infections in Children, Adenovirus, Histoplasmosis in Children, Primary Tuberculosis and Progressive Pulmonary Tuberculosis.

Talks on Physical Medicine and Rehabilitation—Dr. Louis B. Newman, chief of the physical medicine and rehabilitation service, Veterans Administration Research Hospital, Chicago, gave an illustrated lecture on "The Role of Physical Medicine and Rehabilitation in Neurological Disorders" before the St. Louis Society of Neurology and Psychiatry in December. He presented another illustrated lecture entitled, "Physical Medicine and Rehabilitation is Part of Total Patient Care" to the staff of the Veterans Administration Hospital at Jefferson Barracks, Missouri.

Santa Fe Medical Chief Moves to Chicago—Dr. John R. Winston, medical director of the Santa Fe Railway, has transferred his headquarters to Chicago from Temple, Texas. Dr. Winston joined the Santa Fe Hospital Association in 1933, was appointed chief physician for the road in 1946 and was elevated to system medical director in 1951.

Personalities—Dr. William L. Waner of Skokie has been elected president of the medical staff of St. Francis Hospital in Evanston. He served his internship at the hospital in 1925-26 . . . Drs. Fred E. Ball and Grant H. Laing of Chicago, and Dr. R. Kennedy Gilchrist of Evanston, have been appointed to the medical division of the $18,500,000 Presbyterian-St. Luke's hospital development program. Dr. Fred O. Priest of Oak Park and William J. Baker of Chicago were previously named as heads of the division . . . Dr. Eric Oldberg, chief of the neurology and neurological surgery department at the University of Illinois College of Medicine, has been named president of the Institute of Medicine of Chicago. Dr. H. Prather Saunders, a past president of the Chicago Medical Society, was elected vice- president . . . Six physicians of the Provident Hospital staff have been awarded service plaques commemorating a total of 225 years on the staff. The doctors honored, and the number of years of service, were: Pedro M. Santos (posthumously), 40 years; William Tate, Jr., 33 years; James M. Allison, 36 years; Homer P. Cooper, 37 years; Roscoe C. Giles, 38 years and T. Manuel Smith, 41 years . . . Dr. Benjamin M. Gasul, Chicago radiologist, has been given the top award in clinical investigation by the Radiological Society of North America for his exhibit showing x-ray studies of congenital malformations of the heart. His exhibit at the society's recent annual meeting in Chicago was prepared in collaboration with Drs. E. H. Fell, R. F. Dillon, C. J. Marienfeld, G. Hait, H. G. Bucheleres and V. Vrla, all of Chicago.

DEKALB

Talk on Abnormal Bleeding—Dr. Irving A. Friedman of the Hektoen Institute, Department of Hematology, Cook County Hospital, discussed the "Approach to the Patient with Abnormal Bleeding" at the January dinner meeting of the DeKalb County Medical Society in Sycamore.

DUPAGE

Panel On Heart Disease—The DuPage County Medical Society cooperated with the Chicago Heart Association last month in presenting a two-man

panel on "Surgery in Cardiac Disease—Indications and Results." Dr. Harry A. Bliss, assistant professor of medicine at the University of Illinois College of Medicine, discussed the medical aspect, and Dr. Orman C. Julian, associate professor in surgery at the same school, presented the surgical aspect. The dinner and scientific meeting was held at the Memorial Hospital of DuPage County in Elmhurst.

LAKE

Election of Officers—Dr. Clarence O. Edwards of Libertyville, has assumed office as president of the Lake County Medical Society. Other officials elected at the society's January meeting were: Drs. Asa L. Myers, Waukegan, president-elect; Sidney J. Kaplan, Waukegan, vice-president; M. J. McAndrew, North Chicago, secretary; James W. Kopriva, Antioch, treasurer; William R. Darnall, Waukegan, grievance committee chairman; John H. Schroeder, Waukegan, grievance committee member (one year); Edward E. DeLong, Waukegan, and Gerald S. Dean, Highland Park, grievance committee members (three years); Clarence O. Edwards, board of censors (three years); Donald C. Nellins, Waukegan, delegate to ISMS (two years), and Sidney J. Kaplan, alternate delegate (two years).

SANGAMON

Dr Mehn Speaks at January Meeting—Members of the Sangamon County Medical Society heard a discussion of "Operative Cholangiography" by Dr. W. Harrison Mehn of Chicago at their regular meeting last month in the Leland Hotel, Springfield. The annual memorial service was presented by Reverend Edward W. Ziegler, D. D. of Springfield's Westminster Presbyterian Church.

Dr. Thomas F. Harmon was named 1957 president of the medical staff at Memorial Hospital, Springfield, and Drs. Douglas M. Gover and Kane Zelle were elected vice-president and secretary, respectively.Dr. Robert E. Bowen, retiring president, will head the medical executive committee.

The medical society's officers for 1957 are: Jacob E. Reisch, president; W. P. Armstrong, vice-president, and William DeHollander, secretary. Delegates to ISMS are Kenneth Schnepp and Darrell H. Trumpe. Serving as alternate delegates will be Thomas F. Harmon and J. Marvin Salzman.

SCHUYLER

Election of Officers—Dr. C. K. Carey has been elected president of the Schuyler County Medical Society. Other officials for 1957 are: V. M. Corman, vice-president; Henry C. Zingher, secretary-treasurer; Joseph M. Zingher, delegate to ISMS, and Russell Dohner, alternate delegate.

ST. CLAIR

December Meeting—A discussion of the medicare program and election of officers featured the December meeting of the St. Clair County Medical Society.

Dr. Vivien P. Siegel, East St. Louis, was chosen president-elect. Other officials named were: Loraine E. Tegtmeier, Millstadt, vice-president; John S. Hipskind, Belleville, secretary; William E. Knaus, East St. Louis, treasurer; Stuart W. Mauch, East St. Louis, editor; Robert A. Chapman, Belleville and Matthew B. Eisele, East St. Louis, assistant editors.

Dr. Howard L. Lange, Belleville, was installed as president.

WILLIAMSON

Dr. Kane Heads Society for 1957—At the December meeting of the Williamson County Medical Society, Dr. Wendell Kane of Herrin was named president. He succeeds Martin May of Marion. Other officers are: Herbert V. Fine, Carterville, vice-president; Hosmer T. Merrell, Marion, secretary, and Martin Melvin May, Marion, delegate at large to ISMS.

GENERAL

Postgraduate Conference—Featuring case histories of diagnostic and therapeutic problems, the first Postgraduate Conference of 1957, arranged by the ISMS Committee on Postgraduate Education and Scientific Service, was held at the Richland Memorial Hospital in Olney on January 31.

Faculty members of the University of Illinois College of Medicine were the speakers in the scientific program, which was divided into three parts, pediatrics, medical and surgical. These phases were covered respectively by Drs. Heyworth N. Sanford, Robert C. Muehrcke and O. V. Renaud.

The Richland County Medical Society was host at a luncheon which preceded the conference. Dr. Frank C. Weber, president of the society, presided at the dinner meeting, at which Dr. Harlan English, 8th District Councilor, delivered an address on "Current Medical Problems Today."

Staley Co. Creates Post of Medical Director—Dr. John D. Bealer, a native of Pennsylvania and an industrial medical officer in the navy until recently, has joined the A. E. Staley Manufacturing Co., Decatur, as medical director, a newly-created post.

Dr. Bealer holds a medical degree from the Jefferson Medical College, Philadelphia, and a master's degree in public health work from the graduate school of Public Health, University of Pittsburgh.

Governor Appoints Dr. Albaum to New Post—Gov. William G. Stratton has named Dr. Joseph Albaum as superintendent of the Lincoln State School at Lincoln. Dr. Albaum has been serving as acting superintendent of the school since November, 1955. He first joined the school's medical staff in 1938.

Physician-Mayor of St. Charles Decides Not to Run—Dr. Ival G. Langum, 76, who has been mayor of St. Charles for 28 years, recently decided that nine terms of office were enough. He said that be-

cause of his age he did not feel up to tackling the job for a 10th successive term. Dr. Langum is a retired physician.

HEW Official Speaks in Chicago—Dr. Harold M. Graning, regional medical director, Public Health Service, Department of Health, Education and Welfare, addressed the Chicago Council on Community Nursing January 28 at the John B. Murphy Memorial Auditorium of the American College of Surgeons. His subject was: "In Sickness and In Health."

Lectures Arranged Through the Postgraduate Medical Education and Scientific Service Committee:

Frederick W. Slobe, member of the Committee on Medical Economics of the Illinois State Medical Society and Director of Blue Cross and Blue Shield, Will-Grundy County Medical Society in Joliet, January 10, on The Pro and Con of Social Security.

Oliver V. Renaud, assistant in the Tumor Clinic of the University of Illinois College of Medicine, Lee-Whiteside County Medical Society in Dixon, January 17, on Tumors of the Head and Neck Area.

Walter J. Reich, professor of gynecology, Cook County Graduate School of Medicine, LaSalle County Medical Society in Ottawa, January 24, on Office Gynecology.

Lowell F. Peterson, clinical instructor in obstetrics and gynecology at the University of Illinois College of Medicine, Knox County Medical Society in Galesburg, February 21, on Common Problems of the Delivery Room.

J. Henry Heinen, Jr., clinical instructor in orthopedic surgery at the University of Illinois College of Medicine, Rock Island County Medical Society in Rock Island, March 12, on Orthopedic Problems of Interest to the General Practitioner.

James E. Segraves, clinical assistant in bone and joint surgery at Stritch School of Medicine of Loyola University, Englewood Branch of the Chicago Medical Society in Englewood Hospital, April 2, on Problems with Three Common Fractures.

Robert A. DeBord, Peoria, member of the staff of St. Francis and associate staff of Methodist Hospitals in Peoria, Effingham County Medical Society in Effingham, April 8, on Thoracic Surgery in Infants and Children.

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:

Alice R. Dakin, clinical associate in pediatrics at Stritch School of Medicine of Loyola University, McPherson School Parent Education Class, January 8, on Your Child's Health.

Charles L. Maxwell, deputy director of Health, Illinois Civil Defense Agency, Woman's Auxiliary to the South Chicago Branch of the Chicago Medical Society, February 4, on Civil Defense.

Percy E. Hopkins, Chairman of the Committee on Medical Service and Public Relations of the Illinois State Medical Society, South Shore Temple, March 8, on Does Society Have a Responsibility for the Health of the Individual?

Marvin P. Padorr, assistant in pediatrics at the Chicago Medical School, Joyce Kilmer Parent-Teacher Association, March 11, on Physical and Emotional Development of the Child.

Y. T. Oester, associate professor and acting chairman of the Department of Pharmacology at Stritch School of Medicine of Loyola University, Toman Library Forum at Toman Branch Library, March 15, on Physiological Effects of Hydrogen Bomb Tests.

Groves B. Smith, Godfrey, superintendent of the Beverly Farm Home and School for Nervous and Backward Children, Okawville Parent-Teacher Association, March 21, on Sex, Morals and the Home.

DEATHS

Orville Everett Barbour*, Peoria, who graduated at St. Louis University School of Medicine in 1919, died October 12, aged 63, of heart disease. He was a specialist certified by the American Board of Pediatrics, member of the American Academy of Pediatrics, fellow of the American College of Physicians, past-president of the Peoria Medical Society and the pediatric section of the Pan-American Medical Association.

Otto Baumrucker, Cicero, who graduated at Dearborn Medical College, Chicago, in 1905, died November 3, aged 80, of coronary thrombosis. He was also a dentist.

Bruce T. Best, Arlington Heights, who graduated at Rush Medical College in 1904, died December 27, aged 80.

Mathew H. Bisdorf*, retired, Des Plaines, who graduated at Jenner Medical College, Chicago, in 1906, died December 28, aged 75. He was former chief of staff at St. Elizabeth's Hospital.

Douglas Boyd*, Highland Park, who graduated at Harvard Medical School in 1922, died December 20, aged 58. He was former chief of staff at the Highland Park Hospital, a past president of the Lake County Medical Society, a fellow of the American College of Physicians, the Institute of Medicine and the Chicago Society of Internal Medicine.

Clinton A. Elliott*, Chicago, who graduated at the Chicago Medical School in 1922, died December 30, aged 64. He was a member of the staff of the Woodlawn Hospital.

J. Omer Hoffman*, Chester, who graduated at the University of Arkansas School of Medicine, Little Rock, in 1934, died September 4, aged 49, of coronary thrombosis. He was past-president of the Randolph County Medical Society and vice-president of the medical staff of St. Clement's Hospital in Red Bud.

Leonard Kernis*, Chicago, who graduated at the University of Illinois College of Medicine in 1943,

*Indicates member of the Illinois State Medical Society.

died December 22, aged 36. He was a specialist certified by the American Board of Anesthesiology and a member of the staff of Michael Reese Hospital.

Nathan K. Lazar*, Chicago, who graduated at the University of Illinois College of Medicine in 1927, died December 14 in Mount Sinai Hospital, Miami Beach, Florida, aged 58. He was a member of the staff of Passavant Hospital and assistant professor of ophthalmology at Northwestern University Medical School.

Raymond J. Meyer*, Chicago, who graduated at the University of Illinois College of Medicine in 1925, died December 23, aged 66. He was a member of the staffs of St. George and St. Bernard's Hospitals.

Donna M. Parker, retired, Peoria, who graduated at the State University of Iowa College of Homeopathic Medicine, Iowa City, in 1888, died in Wilmette, September 28, aged 92, of arteriosclerotic heart disease.

Arthur Silas Porter*, Salem, who graduated at Loyola University School of Medicine in 1916, died August 25, aged 81.

Chester Arthur Price*, Chicago, who graduated at Eclectic Medical College, Cincinnati, in 1919, died October 1, aged 62, of coronary occlusion. He was a member of the staff of St. Bernard's Hospital.

Nathan S. Scheffner, Chicago, who graduated at the Chicago Medical School in 1918, died December 20, aged 63.

William F. Steuber*, Elmhurst, who graduated at Northwestern University Medical School in 1942, died December 31, aged 53. He was a member of the staff of Memorial Hospital of DuPage County, Elmhurst.

William Thomas Stickley*, White Hall, who graduated at the University of Illinois College of Medicine in 1931, died September 5, aged 58, of coronary disease.

Ralph E. Talbott*, Oak Park, who graduated at Rush Medical College in 1935, died January 7, aged 50. He was clinical assistant professor of psychiatry at the University of Illinois College of Medicine.

Anna Weld*, retired, Rockford, who graduated at the University of Michigan Medical School in 1907, died December 2, aged 90. She was one of the first women physicians to be admitted to the American College of Physicians. She was a member of the "Fifty Year Club" of the Illinois State Medical Society.

Minor E. White*, Kankakee, who graduated at Loyola University School of Medicine in 1918, died December 26, aged 69. He was a specialist certified by the American Board of Otolaryngology.

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EDITOR'S DESK (Continued)

chine's gamma radiation is equivalent to a 3 million volt X-ray source. Conventional radiation is in the 250,000 volt range whereas supervoltage radiation is in the million or more range.

The Arthritis and Rheumatism Foundation reports 276 treatment centers now in operation throughout the country. One is in Chicago. Seminars for clergymen have been held at three of our state hospitals. The purpose of these clinics is to acquaint ministers, priests, and rabbis who minister to the mentally ill with the nature of such disturbances and to emphasize the value of the spiritual contributions made by members of the clergy.

Standard birth and death registration statistics have been collected for many years all over the nation and the information provided is used by health and welfare agencies and other groups. The need has long been recognized for comparable, reliable data on marriages. Recently the Public Health Service announced that The National Office of Vital Statistics will adopt an improved system of collecting marriage statistics. These figures will make known certain facts about new families in the 29 participating states and four territories. Such data are needed for community planning and will help heirs and others to locate marriage records. Illinois is not one of the co-operating states.



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BOOK REVIEWS

PRACTICAL PEDIATRIC DERMATOLOGY by Morris Leider, M.D. Associate Professor of Dermatology and Syphilology, New York University Post-Graduate Medical School; Visiting Physician, Bellevue Hospital; Associate Attending Physician, University Hospital, New York University-Bellevue Medical Center; Diplomate of the American Board of Dermatology and Syphilology. With 280 Photographs and 13 Drawings. The C. V. Mosby Company, St. Louis 1956. 413 pages. Price $10.50.

One does not practice pediatric medicine for long before it becomes apparent that more than 20% of the patients have skin lesions either as a primary or secondary complaint. Too often these rashes have been improperly evaluated and treated according to the recommendations of the latest detail man. This situation may be due in part. to the fact that juvenile skin lesions differ from those seen in the adult, that most skin lesions tend to improve spontaneously, that reference texts on pediatric dermatology are few, and such discussions in the larger text books are sparse.

Your reviewer was frankly, delighted with Dr. Leider's book. The first three chapters are definitely didactic, but pleasantly so. Beginning with the basic science aspects of the skin, then the principles of dermatologic diagnosis and of therapy, including an annotated formulary conveniently printed on blue paper, the book then proceeds to a consideration of the various dermatoses. Each chapter begins with a list of its contents. Tables are used to compare and explain various diseases. There are two glossaries of technical and lay terms. The photographs are numerous and excellent.

This book should be seen and examined carefully to be really appreciated and is highly recommended for teacher and practitioner alike.

J.C.Mc.K.

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HANDBOOK OF PEDIATRIC MEDICAL EMERGENCIES by Adolph G. DeSanctis, M. D. Professor of Pediatrics and Chairman of the Department of Pediatrics, Post-Graduate Medical School, New York University-Bellevue Medical Center; Director of Pediatrics, University Hospital, New York University-Bellevue Medical Center; Director of Pediatrics, Gouverneur Hospital, New York City. With the collaboration of Charles Varga, M. D. Portland, Oregon and ten contributors with seventy-three illustrations. Second Edition. St. Louis-The C. V. Mosby Company. 1956. 371 pages. Price $6.25.

The first edition of this handbook, published in 1951 was a valuable and appreciated reference in pediatric emergencies, but was in need of extensive revision. That has been most satisfactorily accomplished by a re-arrangement of material with changes of emphasis, by expansion

(*Continued on page* 62)

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**Stieglitz, E. J., J.A.M.A. 142:1070, 1950.*

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Ascorbic Acid (C)	300 mg.
Folic Acid	3 mg.
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BOOK REVIEWS (Continued)

of subject matter, and by more illustrations and tables.

One of the commonest pediatric emergencies is that due to poisoning. This section has been expanded and made much easier for rapid reference. The list of commercial sources of poisoning is adequate but owing to the enterprise of the manufacturer new names are continuously appearing, and their chemical content ought to be noted periodically by an interested person. One might suggest the inclusion of blank tabulated pages for this purpose.

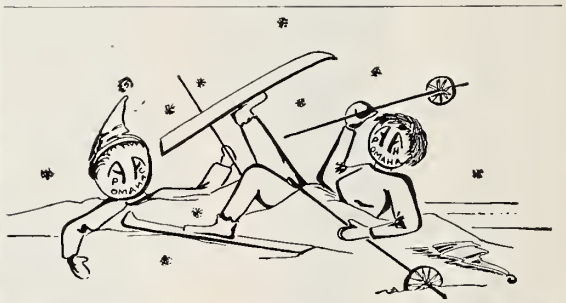
The illustrations are clear and self-explanatory and will be of great assistance to the pediatric nursery supervisor in properly restraining the patient and in providing adequate supplies. This book is recommended for the emergency rooms of all hospitals as well as for practicing physicians. J.C.McK.

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(*Continued on page* 66)



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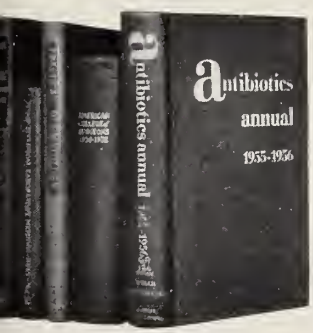
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1. Romansky, M.J., et al., Antibiotics Annual 1955-1956, p. 48,
2. Waddington, W. S., Maple, F. C., and Kirby, W. M. M., A.M.A. Archives of Internal Medicine, 1954, p. 556.

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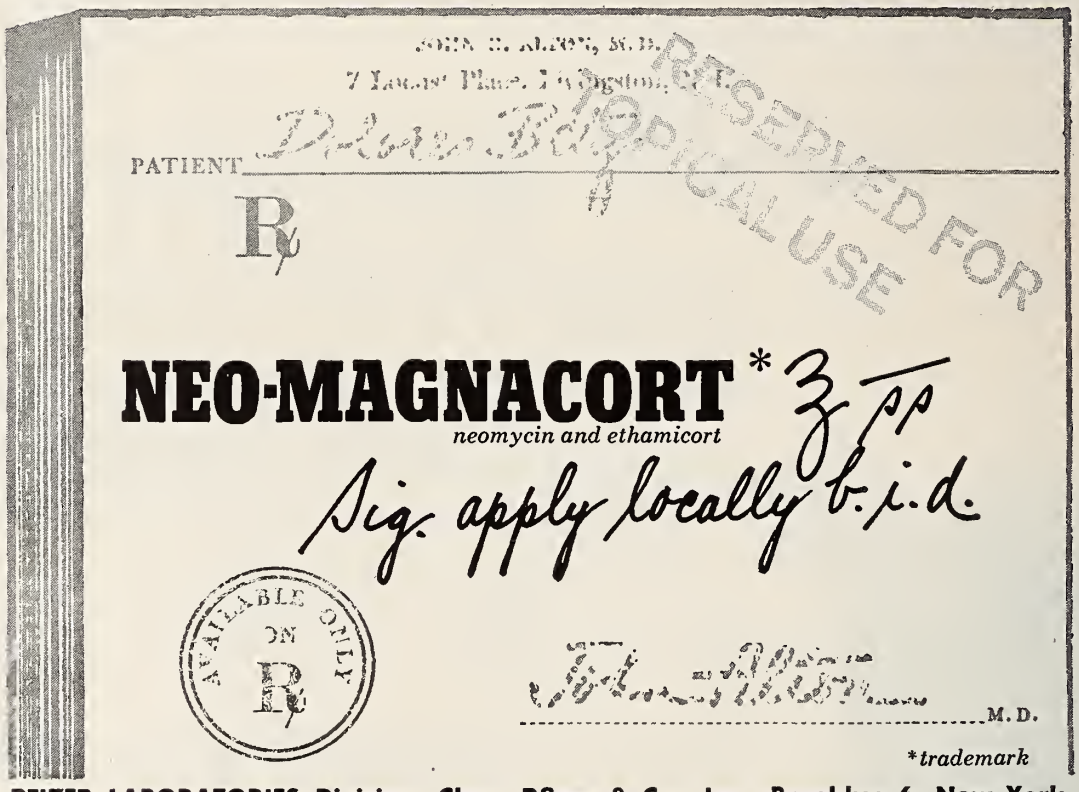
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(*Continued on page* 68)



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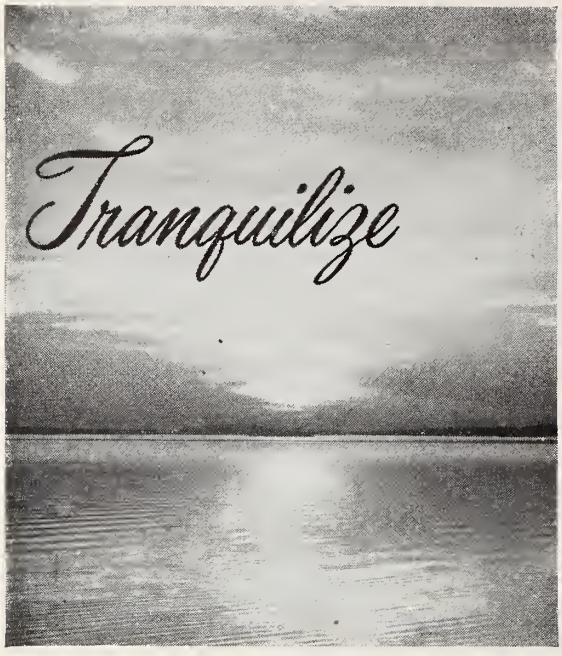
1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc., and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

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(*Continued on page* 70)

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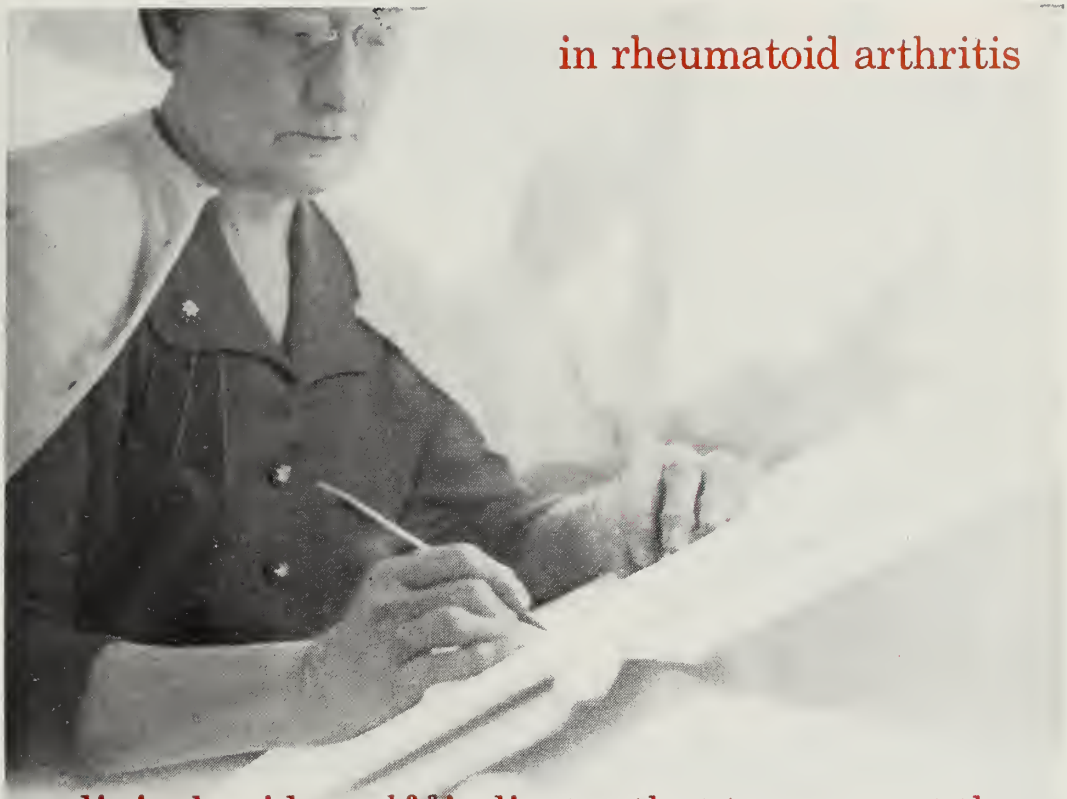
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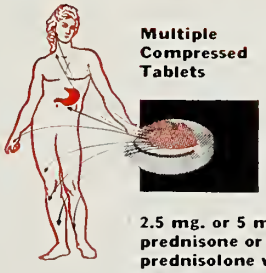
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References: 1. Boland, E. W., *J.A.M.A.* 160:613 (February 25) 1956. 2. Margolis, H. M. *et al.*, *J.A.M.A.* 158:454 (June 11) 1955. 3. Bollet, A. J. *et al.*, *J.A.M.A.* 158:459 (June 11) 1955.

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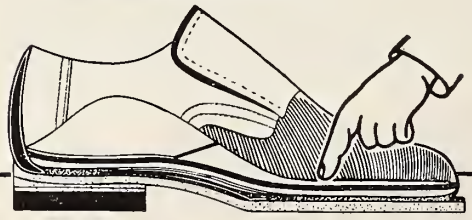


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NEW BOOKS (Continued)

BOYD, W. C. Fundamentals of immunology. 3rd ed. New York, Interscience Publishers, 1956. 776 p. ME2b 380

CHEVALLIER, P. Introduction aux maladies hémorragiques. Paris, Doin 1956. 66 p. ME2b 215

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PENDERGRASS, E. P. The head and neck in roentgen diagnosis. 2nd ed. 2 vols. Springfield, Thomas, 1956. ME2b 421

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BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

THE PATIENT SPEAKS: Mother Story Verbatim in Psychoanalysis of Allergic Illness. Harold A. Abramson, M.D., Associate Attending Physician and Chief of the Allergy Clinic, The Mount Sinai Hospital, New York City; Research Psychiatrist, Biological Laboratory, Cole Spring Harbor; Vantage Press, New York. Price $3.50.

THE PHILOSOPHY OF MEDICINE: By William R. Laird, M.D., Educational Foundation, Inc., Charleston, West Virginia. Price $3.00.

INDUSTRIAL DEAFNESS. Hearing Testing and Noise Measurement. Joseph Sataloff, M.D., D.Sc., (Med.) Assistant Professor of Otology, the Jefferson Medical College of Philadelphia; Visiting Professor of Audiology and Codirector of Industrial Deafness Course, Colby College; Consultant in Audiology, Veterans Administration. The Blakiston Division, McGraw-Hill Book Company, Inc., New York, 1957. Price $8.00.

ANNALS OF THE NEW YORK ACADEMY OF SCIENCES

(1) Staphylococcal Infections. Conference Chairman and Consulting Editor, David E. Rogers. Published by the Academy. Price $4.50.

(2) Techniques for the Study of Behavioral Effects of Drugs. Conference Chairmen: Peter B. Dews and B. F. Skinner. Published by the Academy. Price $3.00.

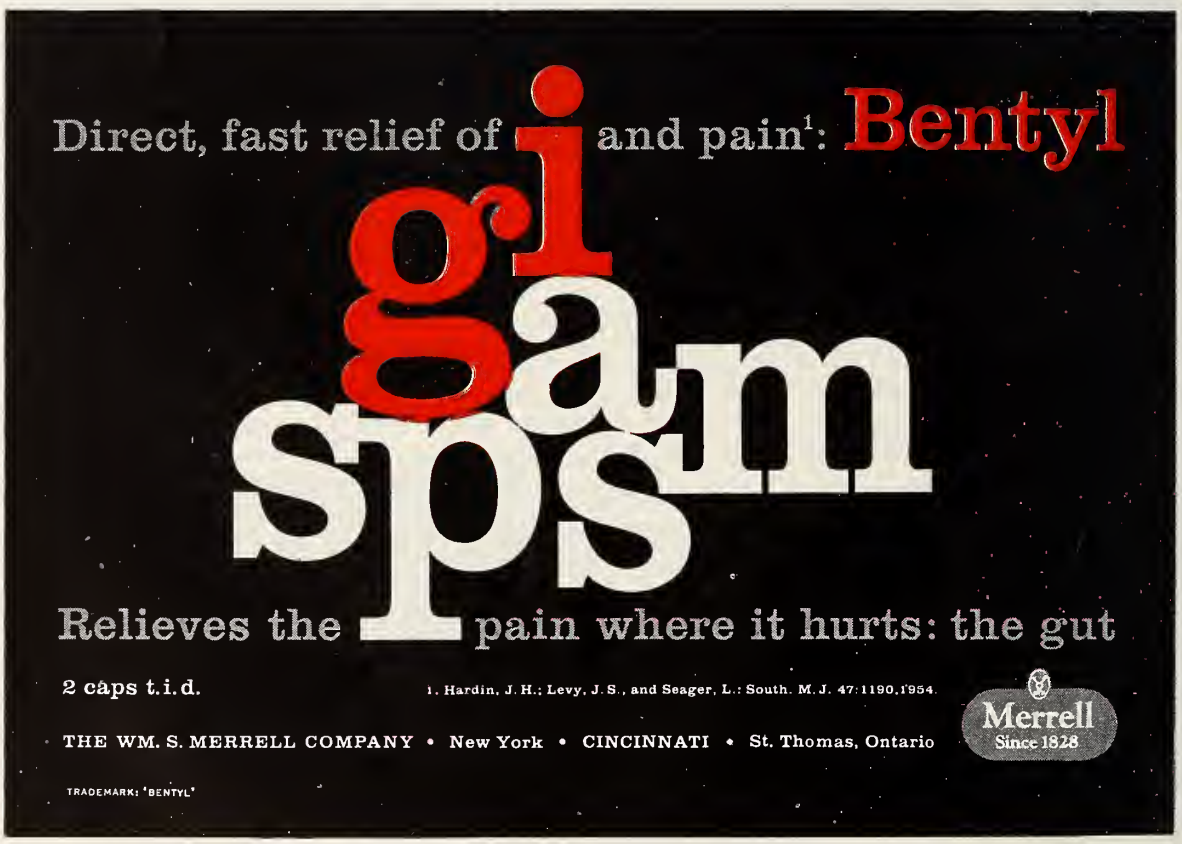
(3) Natural Resistance to Infections. Conference Chairman: Walsh McDermott. Published by the Academy. Price $3.50.

(4) The Evaluation of Autonomic Responses: Toward a General Solution. By John I. Lacey. Published by the Academy. Price $1.50.

(5) Experimental Methods for the Evaluation of Drugs in Various Disease States. Conference Chairman: Bradford N. Craver. Published by the Academy. Price $4.00.

FUNDAMENTALS OF CLINICAL FLUOROSCOPY. Charles B. Storch, M.D. Associate Attending Roentgenologist, Radio-diagnostic Department, Beth-El Hospital, Brooklyn, New York. Second revised edition. Grune & Stratton, New York, and London. 1957. Price $8.75.

CYTOLOGIC TECHNICS FOR OFFICE AND CLINIC. H. E. Nieburgs, M.D. Director, Cytologic Laboratory, Beth-El Hospital, Research Associate, Mount Sinai Hospital, New York City. Grune & Stratton, New York and London. December 1956. Price $7.75.





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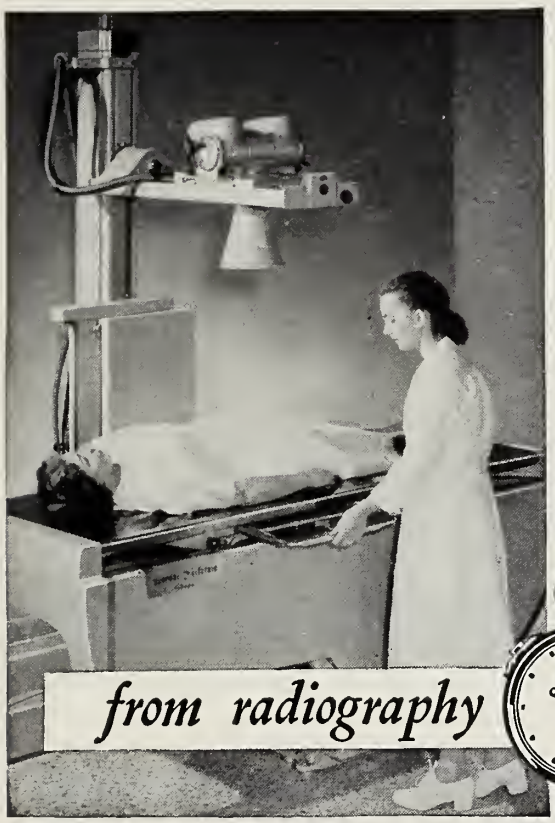
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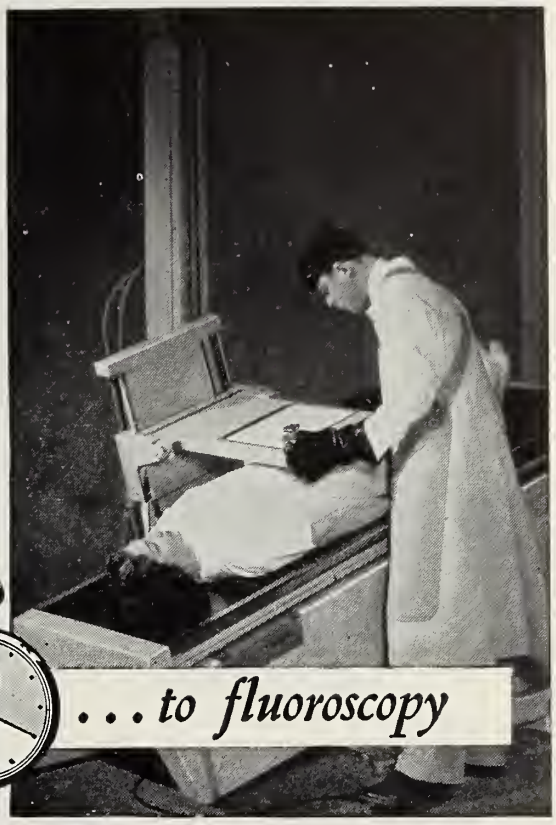
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The Month in Washington



Washington, D. C. — With Congress now well along in its session, the list of health and medical bills totals several hundred. Some are minor — and few persons will be affected regardless of what happens. Others just don't make much sense — and the committees, regardless of politics, can be trusted to let these measures die a peaceful death.

But there are scores of others — all important bills — that have some chance of passage, their prospects ranging from an outside possibility to a strong probability. At this stage they can be regarded as the raw material out of which will come the studies, the debates and the arguments in the months ahead.

One of the major health-medical issues is federal aid to medical, dental and osteopathy schools. On this the administration wants grants for construction and equipment only; some of the Democrats want to include money for operating expenses as well.

In the number of bills introduced, the general subject of problems of the aging probably tops the list. And that is no surprise. For several years welfare workers, housing experts and recreational leaders, as well as physicians, have been looking for ways to help the retirement age population. Recently a special center was set up within the Institutes of Health to devote its time exclusively to the aged. Outside government, voluntary groups have also been at work on the same subject.

Now the ideas developed by the years of discussion are coming to the surface in the form of legislation. Several of the bills would set up commissions, appointed either by the President or Congress. Another recommends that an existing House Committee make a study of the aging, similar to that suggested for the various commissions.

The commissions and committees would have one thing in common: They would further study and investigate in a field that many persons believe already has been plowed and replowed by investigators.

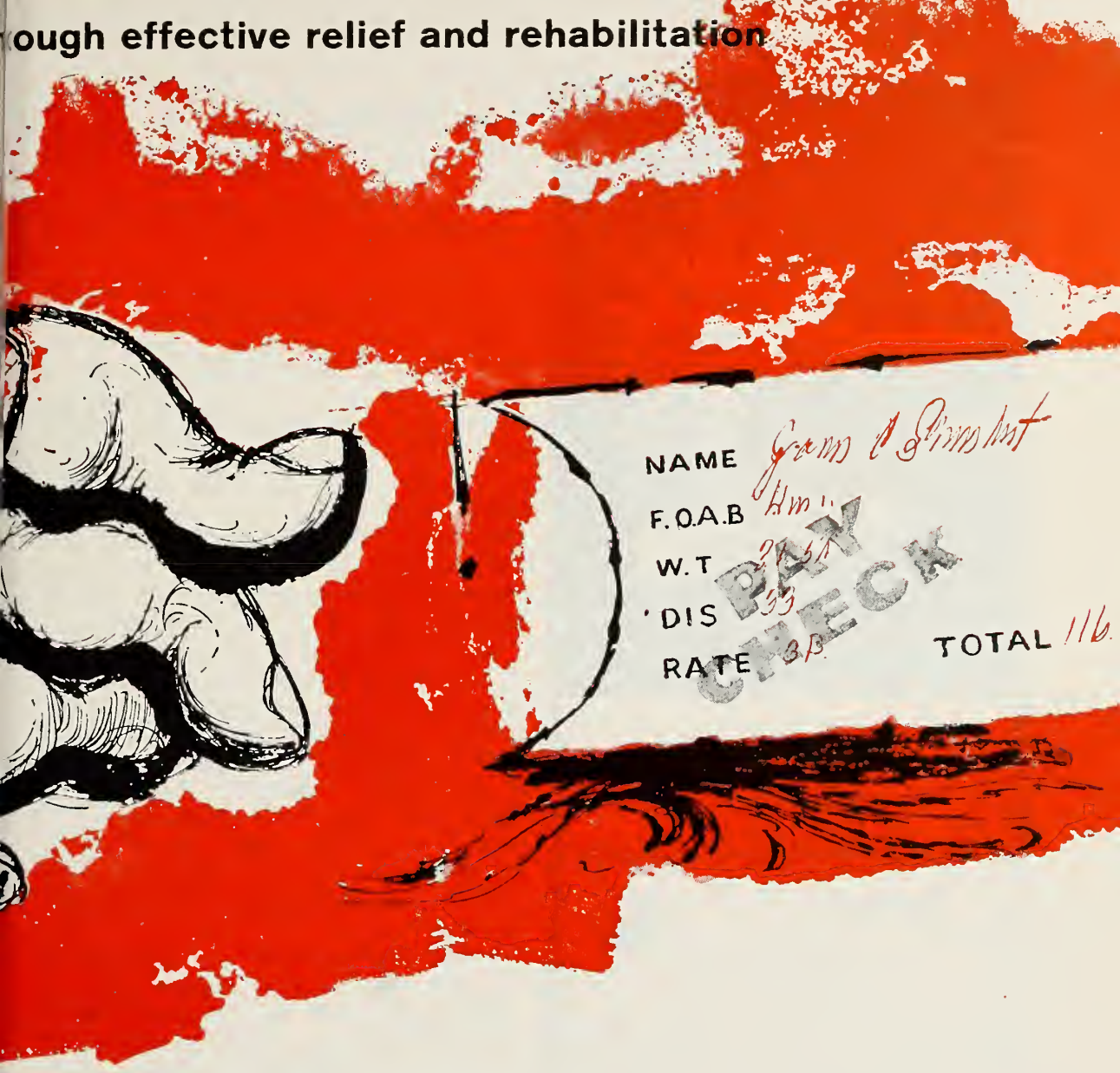
Several lawmakers want to get going right away. They would set up within the Department of Health, Education, and Welfare a new Bureau of Older Persons, which immediately would start out to solve some of the problems through grants, demonstrations and more research.

Most controversial of the "help the aged" bills is one originally proposed by the then Social Security Administrator, Oscar Ewing, in 1951. It would allow 60 days of government-paid hospitalization every year for persons covered by OASI after they reach age 65. They could have this free service whether or not they were on retirement.

As in most Congresses, those who want to get the veterans more benefits and those who think they are getting too much already are coming to grips over new bills. Important in this group is a measure proposed by Chairman Teague (D., Texas) of the House Veterans Affairs Committee that would tighten up procedures under which veterans with non-service-connected conditions receive hospitalization. But at the same time there is pressure from other quarters for a lengthening of the "presumptive periods" for various diseases. Where the law now states that a certain disease or condition will be considered service-connected if diagnosed within one year

(*Continued on page 32*)

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WASHINGTON (Continued)

after the veteran's discharge, these bills would make the period two or three years.

Many other bills aimed at liberalizing veterans' benefits in various ways also are awaiting committee action.

Social security and taxes are other popular fields for the legislators. As expected, several bills call for lowering the age at which a disabled person can start receiving his social security pension, now set at 50. Many measures would change the income tax laws to allow more credit for medical expenses, and one proposes allowing the taxpayer to deduct premiums for health insurance from his income tax itself.

Of major interest to physicians and most self-employed is the Jenkins-Keogh legislation, which would allow deferment of taxes on a portion of income put into retirement plans.

Again, a number of lawmakers want the federal government to take a more active part in control of narcotics, barbiturates and amphetamines and treatment of addicts. One suggestion is to consider any shipment of barbiturates or amphetamines as a part of interstate commerce, on the theory that intrastate control is essential to interstate control. This and other bills also call for strict record-keeping and registration (physicians excepted from these provisions).

A plan introduced in the last session and offered again would give the President the right to assume control over the production, distribution and use of any drugs or biologicals "for use in the prevention and treatment of disease."

Other medical bills will of course be introduced as the session moves on; those discussed here are assured of considerable attention.

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One of man's finest qualities is described by the simple word "guts" — the ability to take it. If you have the discipline to stand fast when your body wants to run, if you can control your temper and remain cheerful in the face of monotony or disappointment, you have "guts" in the soldiering sense. This ability to take it must be trained — the training is hard, mental as well as physical. But once ingrained, you can face and flail the enemy as a soldier, and enjoy the challenges of life as a civilian.

—Col. John S. Roosma

The
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Medical Journal



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Thoracic Surgery and the General Surgeon

Jerome R. Head, M.D., Chicago

GRADUALLY and reasonably, as the fields open to surgery have increased and widened and become more complicated, surgeons have become specialists. Even the general surgeon, although he may not know it and may not like to admit it, has been so encroached upon by proctologists, gynecologists, orthopedists, thoracic surgeons, brain surgeons, plastic surgeons, tumor surgeons, and vascular surgeons, he has become a specialist also.

The whole process has been reasonable and, up to a point, healthy. My purpose in this paper is not to suggest that it be reversed; that the so-called general surgeon take up thoracic surgery, or that the thoracic surgeon take over surgery of the spleen, the cardiac end of the stomach, or the kidney and the splanchnic nerves simply because those areas are best exposed by incisions that enter the thorax as well as the abdomen.

The purpose is to suggest that some basic training in thoracic surgery is as important to the so-called general surgeon as is a training in general surgery to the thoracic surgeon. The latter has been emphasized; the former has been overlooked. There are a great many emergencies where it is essential that whatever surgeon is at hand open the chest, and there are many operations in the upper abdomen and upper retroperitoneal space that can best be performed through combined thoraco-abdominal incisions.

However, opening the chest brings into the picture a whole group of problems in respiratory physiology and possible postoperative complications, which are understood and easily met and handled by the thoracic surgeon, but which are foreign to the thinking of the abdominal surgeon. In this paper, therefore, it is my purpose briefly to run over situations in which it is essential that the abdominal surgeon open the chest, to describe the incisions by which in these situations the chest can best be opened, and, most important of all, to describe the method of handling the problems in respiratory physiology which opening the chest brings into the picture and the method of preventing and handling postoperative complications peculiar to thoracic surgery.

1. *CARDIAC ARREST.* At any time during any operation the heart may stop beating. When this happens it is essential that whoever is at hand open the chest immediately and start massaging the heart. This can best be done through an anterior incision through the 4th intercostal space. The incision extends in the direction of the ribs from the midsternum to the midaxillary line. The pleural cavity is entered through the 4th intercostal space; the 4th and 5th cartilages are cut close to the sternum. Retraction can be by hand retractors or by the ordinary Balfour self-retaining retractor.

2. *STAB WOUNDS OF THE HEART.* The same incision is the one of choice for repairing stab wounds of the heart. Opening the pericardium entails some danger. It is easy to incise through it into the heart muscle. It can be opened most easily and safely by lifting it away from the heart with an unthreaded needle, making a small opening with the scissors just under the needle, and then extending this by cutting with one blade of the scissors inside the pericardium. Sutures in the heart muscle must be handled gently and tied relatively loosely. The heart muscle is a good deal like fresh Swiss cheese and sutures tied too tightly cut through it.

3. *THORACIC TRAUMA. Thoraco-abdominal gunshot wounds* often can best be handled through thoraco-abdominal incisions which permit repair of both the abdominal and thoracic viscera and of the diaphragm.

Penetrating stab or gunshot wounds of the pleura and lung require immediate surgery only for persisting and threatening hemorrhage or for tension pneumothorax. Any sucking wound must be closed immediately. Serious bleeding from the lung or the intercostal arteries is rare. The internal mammary artery, on the other hand, often bleeds seriously until ligated. Stab wounds close to the sternum frequently sever it. Dr. Hudson, one of my associates, recently successfully repaired a superior vena cava which had been pierced by a bullet.

Accumulations of blood in the pleural cavity, whether resulting from surgery, spontaneous hemopneumothorax, or trauma, present an important problem. Usually bleeding stops spontaneously and blood in the pleural cavity does not clot. In such cases, after a day or two, when danger of restarting bleeding by re-expansion has passed, the blood can be aspirated. When, however, the blood clots and cannot be aspirated, something must be done about it lest the lung become permanently bound down and crippled by the formation of a thick layer of organizing fibrin on the visceral pleura. During the first week the injection of streptokinase and streptodornase frequently will dissolve the clots so that the blood can be aspirated. If this fails, surgery is indicated for peeling the lung. The time of choice for this operation is four to six weeks after the injury. Too early operation makes peeling difficult and too late operation makes it more difficult. This is not an emergency operation and had best be turned over to a thoracic surgeon experienced in the technique.

Traumatic pneumothorax requires emergency treatment only if it is large and progressive. Under these conditions it will cause dyspnea. It usually can be controlled and corrected by inserting a blunt retention needle into the chest and connecting it by a rubber tube to a water trap. If this does not control it, a catheter should be inserted into the pleural cavity through a cannula and this connected either with a water trap or a suction machine. Occasionally, even this is not sufficient, and operation is indicated. Dr. Hudson recently operated successfully upon a patient with a crushing injury where the right main bronchus had been severed completely. The bronchus was sutured end to end and the patient recovered.

Traumatic subcutaneous emphysema is serious only if it reaches the subcutaneous tissues by way of the mediastinum. Usually it is a complication of traumatic pneumothorax in which case the air escapes from the pleura through tears in the parietal pleura. This is easily and quickly controlled by the insertion of a catheter into the pleural cavity. Occasionally, however, even without pneumothorax, the lung is torn internally in which case air travels along the great vessels into the mediastinum. Such emphysema is often progressive, the patient blowing up to an absurd extent. Pressure of the air in the mediastinum mounts and pressure on the great veins prevents return of blood to the heart. In such cases, immediate operation is imperative to relieve mediastinal pressure. The chest should be opened, the mediastinal pleura widely incised, and the emphysema thus converted into a pneumothorax which can be controlled by an intrapleural catheter.

Flail chest. Multiple anterior rib fractures can so mobilize the chest wall that the respiratory movements of the mobilized segment move in a paradoxical manner. This interferes seriously with respiration and with the efficiency of cough and evacuation of secretions. Until recently the treatment has been to stabilize the chest by binders and sandbags. This was usually unsatisfactory. Several years ago Dr. Hudson and Dr. McElvenny, confronted with such a

case, applied soft tissue traction by inserting multiple Steinman pins under the pectoral muscles and applying overhead traction. This worked. More recently Dr. Avery has used continuous mechanical positive pressure breathing through an intratracheal cannula inserted through a tracheotomy opening. This does away with all muscle pull and the positive pressure holds the chest wall out permitting healing of the ribs in a normal position.

Tracheotomy to permit frequent aspiration of the tracheobronchial tree is life saving in severe chest injuries, particularly those associated with head injuries. Secretions must be evacuated and aspiration every hour or half-hour through a tracheotomy tube is a sure way of accomplishing this. In these cases, progressive waterlogging of the lung by retained secretions is the great danger.

We come now to those operations of choice on the viscera of the upper abdomen which often, if not usually, can best be performed through combined thoraco-abdominal incisions. In this field the abdominal surgeon who has had basic training in the operative and postoperative handling of the open chest has a great advantage.

I shall not mention diaphragmatic hernia. This is best repaired through a thoracic incision and is properly in the field of thoracic surgery. The operation carries practically no mortality. When properly performed with good exposure, recurrences are rare.

Splenectomy, pancreatectomy, total gastrectomy, and in some cases nephrectomy and resection of the splanchnic nerve become relatively easy operations when a thoraco-abdominal incision is used. The classical incision for the upper abdomen extends from the posterior axillary line in the 7th intercostal space downward and forward across the costal arch and then either transversely across the rectus muscles or downward in the midline or over the left rectus. The costal arch is cut across, the pleural cavity is entered through the 7th intercostal space, the diaphragm is incised to and including the esophageal hiatus, and rib spreaders are inserted. Through this incision the lower esophagus, the cardiac end of the stomach, the body and tail of the pancreas, and the spleen are completely exposed.

For nephrectomy and operations on the splanchnic sympathetic nerves the incision is posterior through the 11th rib or the 10th intercostal space. Through this, the diaphragm is incised and the entire upper retroperitoneal space widely exposed.

The real and truly important problems incident to opening the thorax are much more specific. They are not easily or quickly learned, but on them depends the survival of the patient. They concern: anesthesia, exposure, and postoperative care.

Anesthesia must be intratracheal by a physician anesthesiologist. It should be controlled and mechanical. To avoid any danger of cardiac arrest from hypoxia or hypercapnia the patient should be overventilated.

The classical position of the patient is lateral or approaching somewhat the face-down position. The patient must be bolstered and strapped in the desired position. The classical posterior incision is from just lateral to the spine downward and forward to the midaxillary line in the direction of the ribs. The chest may be opened either through an intercostal space or through the bed of a resected rib. When the intercostal space is used it often is desirable to cut one or two ribs posteriorly close to the transverse processes. When this is done or when a rib is resected, the intercostal nerves must be severed; otherwise the stretching of the nerves incident to spreading the ribs may cause an intractable, persisting intercostal neuritis. At the close of the operation, the cut ribs should be pegged back together with intermedullary pegs.

The classical anterior incision has already been shown. It extends from the sternum outward and upward to the midaxillary line in the direction of the ribs — in the third intercostal space for operations on the lung or mediastinum, through the fourth for operations on the heart.

The pleural cavity should always be drained by one, two, or three tubes inserted through intercostal spaces. These should extend from the base of the pleural cavity to the apex where they should be lightly sutured to the parietal pleura. The posterior tube should have multiple holes, the lowest one just inside the chest; the anterior tube should have holes only at and close to its tip. While the patient is still on the operating table the tubes should be connected to a water trap lest he develop tension pneumothorax on the way to his room.

In the room, the tubes should be attached to a suction pump. An efficient pump that will produce high suction and will run indefinitely without heating is essential. Oxygen should be available and also a suction pump with catheter for aspirating the tracheobronchial tree.

The problems are complete re-expansion of the lung, complete aspiration of air and fluid, and adequate evacuation of bronchial secretions. Expansion of the lung must be checked frequently by X-rays. Patency of the tubes must be assured by frequent injections of small amounts of antibiotic solution. If X-ray shows that the lung has not completely expanded, either the tubes must be flushed and adjusted, another tube must be inserted, or the chest must be re-opened.

The evacuation of bronchial secretions is a great and persisting problem. Thoracic incisions are so painful that to induce the patient to cough is difficult. He must be frightened and told that he will die if he does not cough. He must be sat up in bed and made to cough. Water must often be injected into his trachea to make him cough and usually his trachea and bronchi must be aspirated through a catheter directed into them or even through a bronchoscope.

The postoperative problems incident to opening the chest are important and difficult. It is in this field that untrained abdominal surgeons most frequently fail and this failure is responsible for their high mortality. I would advise no one to enter the field without some training, without adequate equipment, or without trained assistants unless he is prepared to be in the hospital three or four times a day around the clock. When conditions are right, training adequate, and equipment and personnel available, thoracic surgery is extremely safe.

In closing, I would repeat that training in the general principles of thoracic surgery should be part of the training of any abdominal surgeon. It is as important as is training in general surgery for the thoracic surgeon. The abdominal surgeon who has such training will be able to deal intelligently with the emergencies of thoracic trauma and will be much more at ease in the upper abdomen and the upper retroperitoneal space.

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Cancer surgery

Age per se should not be an important determining factor in the decision regarding major excisional surgery for cancer in elderly patients. There is no incomplete operation for cancer. Either the growth should be excised entirely or nothing should be done unless there are acute obstructions which can be easily relieved without removal of the growths producing them. However, surgeons are now getting away from palliative, short-circuiting operations and are carrying out excisional procedures which relieve obstructions, even though distant extension of disease is not resectable — for example, excisions for obstructing gastric or colonic lesions in the presence of hepatic metastases. The attitude that the elderly cancer patient, whose life expectancy under normal circumstances is not very long, should be spared the risk of total excision of the cancer, but subjected to short-circuiting operations if necessary, is becoming less tenable. It is not the age that constitutes poor surgical risk, but the extent of cardiorenovascular impairment. Individuals in advanced age groups often are more fit to withstand the strain of radical surgery than are persons younger in chronologic age. There are exceptions but these are made for each individual situation and based upon judgment formulated by experience. *Alexander Brunschwig, M.D. Age of Patients in Relation to Radical Cancer Surgery. Geriatrics. Sept.* 1956.

High Blood Pressure vs. Hypertensive Disease

J. C. Lockhart, M.D., Peoria

THE theme of this presentation is simple: We should make a clearer distinction between high blood pressure and hypertensive vascular or cardiovascular disease. High blood pressure is common. Hypertensive vascular disease is far less common. High blood pressure is a threat to the individual primarily because he knows he has it and because he "knows it is bad." Hypertensive vascular disease is a threat to the individual because it actually leads to death several years before the alloted life span is over. The confusion of the two is the responsibility of the medical profession and resolution of the confusion is our duty.

Re-evaluation of basic concepts often is a rewarding process. Especially is this true when the superstructure of therapy has extended so rapidly it threatens the stability of the foundation of cause and effect. There are now available and in use many potent hypotensive drugs and surgical procedures. They all have powerful and frequently undesirable side effects, resulting either directly or indirectly from their hypotensive action. Some are dangerous and even fatal, and sometimes the psychological import of their use results in an iatrogenic cripple.

This brings up the question: Is treatment necessary? The first difficulty we encounter is in deciding whether an individual has high blood pressure. Recent compilations have assured us that blood pressure varies with age, [1,5] sex and weight. Among all the variables, all agree that a diastolic pressure of 110 or over is abnormally high. Mathiesen of Oslo[2] has reported normal mortality statistics for those whose diastolic pressure falls below 95, either with rest or medication. East and Bain[3] consider 160 the top limit of normal systolic pressure, while Evans[4] is much more lenient and allows 180 systolic and 110 diastolic before hypertension begins. Pickering[5] believes there is no definite dividing line between normal and pathological blood pressure levels.

A valiant attempt to clarify the situation has been made by Master and associates[1] and I would commend his excellent article for your consideration. They have concluded that a man 20 years old may be considered to have normal blood pressure up to 140 systolic and 88 diastolic. He is hypertensive when the systolic is over 150 or diastolic, over 95. Between 140 and 150 systolic and between 88 and 95 diastolic is the borderline area, the significance of which can be determined only after repeated and careful examinations. When this man is 40, he may legitimately have a systolic blood pressure up to 146 and a diastolic up to 94 and still be within normal limits. Hypertension for this man of 40 begins with a systolic of 158 or diastolic of 100. At the age of 60 he has even more latitude: normality extends to 165 systolic and 100 diastolic, and hypertension does not begin until his blood pressure remains at 180 systolic or 110 diastolic.

Not only does blood pressure vary with age, but it varies with sex and weight. Height seems not to have any influence.[1] Hypertension is found to be two times as frequent in females.[6] Master[1] found that blood pressures in women are higher than those given for men in age groups after 20. There is a correlation between obesity and elevated blood pressure, and there is evidence that elimination of excess weight alone may reduce a previously high blood pressure to normal.

The normal, or ideal, blood pressure therefore is non-existent. Consideration must be given to age, sex, weight, the conditions under which the blood pressure is determined, and the constancy of the values.

Having decided that our individual patient does have high blood pressure, we are faced with the next important decision: Is treatment necessary? In order to answer that we need to know

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Presented before the Section on Cardiovascular Disease, the Annual Meeting of the Ill. State Med. Soc., Chicago, May 15, 1956.

what that high blood pressure means. What will it do to him? Again, we receive a shock. No one can tell us what to expect in an individual who has high blood pressure and nothing more. We simply do not know his life history. In a general way, we are told that the average age at death of a large group of hypertensive individuals will be younger than that of a similar large group without hypertension. Wakefield[11] has found that women may live in harmony with their high blood pressure for 30 to 50 years, and that they tend to maintain the same hypertensive levels throughout the seventh, eighth, and ninth decades regardless of treatment. Kyser[12] has also noted the benign nature of hypertension in elderly people and recommends reassurance as the most beneficial treatment. Bechgaardt,[13] in a most excellent review of over 1,000 hypertensives found that after 10 to 12 years one-half were in good health and that one-fourth were without symptoms.

In contrast to generalizations about large groups, we know more about each individual. We know his past history, present physical state, symptoms, whether there is evidence of cerebral, cardiac, or renal abnormality, and the appearance of his retinal arterioles. On the basis of this detailed information, differentiation must be made between a simple elevation of blood pressure and hypertensive disease. The former is without specific meaning and forecasts nothing. The latter is a progressive disease leading to the death of the patient at an abnormally early age from cerebral, cardiac, or renal complications. Gold[7] has emphasized that "hypertension does not label a disease but a number of diseases with different life histories and different causes."

With the possible exception of congestive failure, so-called complications of hypertension are the results of degenerative changes in the blood vessels.[8]. It is for this reason that we have been urged to shift our emphasis from the level of the blood pressure to the behavior of the blood vessel walls. That the two processes-high blood pressure and arteriosclerosis — often co-exist is good enough reason to look for one when the other is present, but it is hardly sound enough reason to label one as cause and the other effect. Martin of France[9] and Griffith[10] are among those who now label cerebrovascular accidents, coronary heart disease, and nephrosclerosis among the end results of degenerative vascular disease and not of hypertension. Master[1] has said that hypertension has no prognostic significance in coronary heart disease. There is doubt that hypertension can be regarded as a cause of coronary heart disease. Sigler[6], investigating a series of his patients, found that while hypertension was twice as common in the women, coronary heart disease was four times as common in men. He rightly draws attention to the soft, smooth walled coronary arteries frequently seen in the hypertrophied heart of hypertensive heart failure. Wakefield[11] says that the level of blood pressure did not influence the angina of his elderly women. Even those dreadful symptoms of hypertension that used to be the excuse for any kind of therapy are now denied to be due to the high blood pressure, and are ascribed to tension and anxiety. Wood, of London's Heart Hospital,[8] stated there are no symptoms of uncomplicated hypertension, and that the complications were the result of vascular disease and not of hypertension.

What then is hypertensive vascular disease? It is a disease manifested by a constantly elevated blood pressure and the appearance and progression of degenerative changes in the smaller arteries. Whether these factors are due one to another, or to a third factor, we do not know. It is seen primarily in young people. It may have a rapid and acute course with diastolic blood pressure always in excess of 120, in which case we call it malignant hypertension. It may have a relatively benign and slow course, and then we wonder if it is the same disease.

High blood pressure of itself is not a disease and needs no treatment except reassurance for those who know of it, and failure to tell the others of its presence. Hypertension with arteriolar damage is hypertensive vascular disease, called essential if no cause is found. Treatment depends on rapidity of progression, age, and presence of complications. Those with a slowly progressive course and long periods of stability cannot be successfully treated. The elderly patient almost always will have the benign form, does not need treatment and usually does not respond to it. Those with cardiovascular and coronary heart disease often do not tolerate hypotensive agents, the use of which may result in intensification of symptoms or the appearance of fresh vascular accidents.

SUMMARY

High blood pressure must be determined in each individual according to his own characteristics. High blood pressure is not a disease of itself. If high blood pressure is associated with degenerative vascular disease there may be increased mortality. In young individuals with progressive disease, treatment may be desirable.

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Ecology

Ecology is the relationship between various living organisms in an environment and of their reactions to their animate and inanimate surroundings. Human ecology is the study of the whole man's habits and modes of life and his relations with his surroundings. Ecology denotes the close relationship between all living things and in considering the definition for infection we find that the host-parasite relationship is an ecologic phenomenon. Now, the host-parasite relationship may result in apparent or subclinical infection, apparent or clinically recognizable infection (disease), and death. As medically trained individuals, we have looked upon the disease and death components of infection as particularly undesirable. Actually, the host-parasite relationship results in disease and death only occasionally and the factor of inapparent infection is, by and large, more important for in this situation, the adjustment of host and parasite has not been inimical, but valuable. Nearly always, inapparent infection results in protection of the human host against severe disease or death. In thinking of certain wild animals, predation is called to mind, a preying of one animal upon another. This can hardly be stated of the host-parasite relationship. However, it is an example of parasitism, for the word "infection" in the equation — infection equals host plus parasite plus environment. Looking upon parasitism or infection from the standpoint of the parasite, it must be immediately obvious that survival of the parasite is dependent upon the well being of the host. If the host is critically ill, it will be to the detriment of the parasite; and if the host dies the parasite will likely die. Thus, in terms of the parasite, disease and death are evidences of a bungling parasitism. The relationship which is optimal to both host and parasite is commensalism — a mutual but almost inconsequential association between a parasite and its host. *F. H. Top, M.D. The Changing Character of Infections as the Result of the Era of Chemotherapy. Minnesota Med. Oct.* 1956.

The Hemorrhage Problem in Otolaryngology

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THE mechanism and management of hemorrhage in the field of otolaryngology has not been a well defined and satisfactorily organized area in our field of practice. It is also not uncommon. My own practice in a comparatively small central Illinois town has put me to several severe tests during the past five years. Although there have been no fatalities, Providence was most kind on at least two occasions. In addition to the bleeding problems of my own cases, I have frequent consultations regarding postoperative problems of bleeding because I practice as a specialist in a small city of a rural area. A large traumatic service, consisting mostly of cases resulting from automobile accidents with injuries of the face, jaws, and neck, contributes another group with extreme bleeding complications. Also among a group of referred patients for bronchoesophagological work there are a significant number of idiopathic pulmonary or esophageal hemorrhage cases.

Altogether, bleeding problems, either preoperative, postoperative, or posttraumatic are quite common in our field and if they prove severe enough, are brought to the attention of the ENT specialist. In many instances, these bleeding problems are only of nuisance character but even so the busy practitioner often finds it difficult to afford them the necessary time from a day that is already too full of commitments. For these reasons an attempt is made to organize a program for their management. A list of some of the most frequently encountered problems is as follows:

Ear:

a. Cutaneous bleeding from the temporal area.
b. Hematoma formation of the auricle and reformation after aspiration.

Nose:

a. Polypectomy - ethmoid or antral mucosa bleeding.
b. SMR - mucosal bleeding from tear over spur.
c. Nasal fracture work - anterior ethmoidal bleeders.
d. Tumor - bleeding carcinoma of the antrum.

Nasopharynx:

a. Adenoid - postoperative bleeding.
b. Mixed tumor of nasopharynx.
c. Trauma - pyramidal maxillary fractures with bleeding from paravertebral area.

Pharynx:

a. Tonsil - postoperative bleeding.
b. Tongue - hemiglossectomy with posterior bleeding.
c. Trauma - perforating mandibular fractures.

Bronchoesophagological:

a. Idiopathic pulmonary bleeding - varix.
b. Esophageal - varix, ulcer, or trauma.

In many instances, bleeding following operations on the nasal passages or pharynx has been a real nuisance. No paper on postoperative bleeding could be written without some mention being made of measures taken preoperatively to disclose the probability of operative or postoperative bleeding and to prevent its occurrence when possible. This brings us immediately to the problem of the efficacy of laboratory tests in ferreting out bleeding problems before operations. In the past, and very much in the present, much blind reliance has been placed on bleeding and clotting time tests in the hope that they will accomplish the above. The great majority of cases of postoperative hemorrhrage in ENT surgery results from causes other than blood dyscrasias. In spite of the fact that blood dyscrasias as causes of hemorrhage are unusual in this field, it is still necessary to guard against them. Furthermore, if you do have a blood dyscrasia case, i.e. trauma, you should be prepared to diagnosis it quickly and treat it specifically.

What is the best method of screening so that

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one may feel safe and at the same time, not carry out unnecessary procedures? The best safeguards are a good history and a careful examination of the blood smear. A well taken history should detect episodes of bleeding of either the hemophiliac or purpuric type. A good examination of the blood smear well reveal anemia, leukocyte change, and thrombocytopenia. It also will reveal an early leukemia and early leukemia is the most common blood dyscrasia which causes postoperative bleeding.

This type of examination and preoperative preparation is much more valuable than placing blind reliance on the bleeding and clotting time. The clotting time is abnormal in only two types of bleeding and both are rare. These are hemophilia or hemophiloid states and hypoprothrombinemia. A careful history should bring these to light. What is more, either of these conditions may exist without a prolonged clotting time. For practical purposes, the examination of the blood smear will give you the same information gained from the bleeding time test, for bleeding time is proportioned to the number of platelets present. With only rare exceptions does one find a prolonged bleeding time without finding a concomitant lowering of the platelet count. Therefore, the blood smear will give you the information wanted and it has fewer pitfalls than the bleeding time. It seems obvious from the above that the common practice of doing red, white, and hemoglobin determinations but leaving out the blood smear is omitting the most important single examination.

What do you do when there is a history of bleeding? Here, a simplified yet careful study of the clotting mechanism must be done. This can be initiated by performing the plasma clotting time and prothrombin time. The platelet count may be omitted for it has already been observed in the blood smear. The use of the plasma clotting time and the prothrombin time together must be emphasized. The reason for this is that when both are normal, there is no defect in any of the hemophiliac factors nor in the platelet or the prothrombin factors including the stable and labile factors. In other words, there is no defect in the coagulative mechanism. This does not exclude the types of bleeding due to capillary fragility (Osler-Weber) but these should be picked up in the history.

If the plasma clotting time is prolonged and the platelet count and the prothrombin time are normal, then the defect is in one of the hemophiliac factors (antihemophiliac globulin, plasma thromboplastin component, or plasma thromboplastin antecedent). If the plasma clotting time is prolonged but the platelet count very low and the prothrombin time normal you are dealing with potential thrombopenic bleeding. If both the plasma clotting time and the prothrombin time are prolonged and the platelet count is normal, then the defect most commonly is in the stable factor. But it can be of the labile factor, fibrinogenemia, or a true hypoprothrombinemia. These are extremely rare. All of these can be identified by additional specific procedures under the guidance of physicians trained in the laboratory aspects of the clotting mechanism. Below you will find an outline of the laboratory tests which gives you this information.

	Plasma Clotting Time			
	Fresh Normal Plasma	Aged Plasma	Absorbed Plasma	Normal Serum
Anti-hemo-glob.	pos.	neg.	pos.	neg.
Plasma thrombo-comp.	pos.	pos.	neg.	pos.
Plasma-thrombo add.	pos.	pos.	pos.	pos.

	Prothrombin Time			
	Dicoumarol Serum	Normal Serum	Aged Serum	Absorbed Serum
Labile	neg.	pos.	pos.	neg.
Stable	pos.	neg.	neg.	pos.

It can thus be said that a careful history, together with a careful examination of the blood smear is the safest procedure that can be carried out prior to surgery and that when the history indicates a bleeding tendency, a survey of the clotting mechanism is in order. If you are confronted with a history of bleeding and an absence of any defect in the clotting mechanism then you must be dealing with one of the forms of vascular purpura.

The following is an outline of the most recently accepted theory of blood coagulation

which might help you to understand the previous discussion.

Platelets:

Thromboplastinogen
- a. Antihemophiliac Globulin
- b. Plasma Thromboplastin Antecedent
- c. Plasma Thromboplastin Component

Thromboplastin

Co-factors 1. Labile
2. Stable

Prothrobin

Thrombin

Fibronogen

Fibrin

Clot

Therefore:

1. History
2. Platelet count and blood smear
3. Prothrombin time (Quick)
4. Plasma clotting time

Tells whether or not you have a blood dyscrasia:

1. Purpura (thrombocytopenia)
2. Occult leukemia
3. Capillary fragility (Osler-Weber)
4. Hemophilia
5. Hypoprothrombinemia
6. Hypofibrinoginemia

Any approach to a postoperative bleeding problem will depend upon the history, the site of bleeding, the condition of the patient, and any antecedent disease or injury that might bear upon the problem. A short talk with a responsible member of the patient's family will bring to light any previous bleeding episodes or purpuric tendencies. A careful look at the blood smear will reveal any occult leukemia or platelet deficiency.

If one finds a blood dyscrasia, the best early treatment is:

1. Hemophilia - transfuse fresh whole blood, pack with Oxycel.®
2. Leukemia - fresh whole blood.
3. Hypoprothrombinemia - Vitamin K
4. Hypofibringoinemia - fibrinogen
5. Purpura - fresh whole blood
6. Capillary fragility - bioflavinoids - ? Rutin

The above discussion and outline covers the management of bleeding because of a blood dyscrasia including the preoperative and postoperative procedures. There still remains the postoperative bleeding problem which is not the result of a defect in the blood clotting mechanism.

I have often thought that it would be helpful to have at hand a prepared list of all the measures by which one might attack a postoperative hemorrhage problem. I think, too, these things should be listed in an orderly fashion so that those which have been proved to be of greater value can be done first and so on down the line. One could then go about controlling postoperative hemorrhage in a more orderly fashion. No criticism is meant of those who rely on transfusions to control hemorrhage; rather, this is an attempt to formulate a more systematic and scientific approach to the problem. There is much divergence of opinion regarding the relative values of vitamin K, calcium, vitamin C, adrenochrome, Premarin,® whole blood, plasma, and sedation in the control of hemorrhage. In the face of a severe hemorrhage one must act and many of us are often guilty of using shotgun therapy and on occasion use all of the above agents on the same case. Is there a better way of handling these problems? Perhaps not. But I have found that by following the listing below, I have had more success and more peace of mind in the knowledge that I am approaching the problem in a more logical fashion.

1. Get a good short history of previous bleeding problems and check a blood smear.
2. Check the prothrombin and plasma clotting time.
3. Use tight, precise local pressure.
4. Use precise astringents if at all possible.
5. Turn to your physiologic aids in the order of their proved importance.
6. Transfuse early if necessary.
7. Sedate mildly.
8. Interrupt the vascular supply only if the above fails.

There are few bleeding points in our field that are not accessible to some sort of pressure packing. The important thing here is to get the packing placed in a precise fashion, pack tightly, and maintain tight packs. At this point we must give some thought to the use of oxidized cellulose. In this case, hemostasis depends upon the marked affinity of cellulosic acid for hemoglobin. When Oxycel is exposed to blood it forms a soft gelatinous mass which adapts itself to the contours of irregular surfaces and con-

trols hemorrhage by acting as a cork in the wound. Since hemorrhage can be controlled only by causing a clot to form in the mouth of a vessel, pressure should be used in conjunction with Oxycel to facilitate the sealing of the mouths of bleeding vessels. Oxycel does not enter into the physiologic clotting mechanism but instead forms an artificial clot. It is, therefore, of some use in hemophilia. There is a variance of opinion regarding how long one should keep a pack in place. My experience has been limited but my training on this matter is that any antral, nasal, or postnasal pack can be kept in place five days without untoward sequelae. Occasionally an odiferous pack will have to be removed earlier.

The use of astringents, when precise local application can be done, has been of great value. Again one's training generally determines what agent to use. I feel that tannic acid is best, for it causes less tissue disruption. Those who use silver nitrate, ferric chloride, trichloroacetic acid, or electrocoagulation will no doubt obtain equally good results.

The use of physiologic aids brings forth a number of questions. Certainly if one has a prolonged prothrombin time, vitamin K in one form or another must be given. But, one must realize that labile and stable factor deficiencies may masquerade as hypoprothrominemia (cause prolonged prothrombin time) and the proper procedures to identify these deficiencies should be carried out. Vitamin K will not be effective if deficiency of the labile or stable factor is responsible for the bleeding.

The use of Koagamin® is purely empirical. The theory is that it either acts as a catalyst to convert prothrombin to thrombin or else it renders the platelets more friable so as to accelerate the liberation of thromboplastin. There is no scientific proof that it does either.

The use of systemic adrenalin has been of value. The role of vessel retraction and contraction in the formation of a solid and fixed clot is well established. While retraction and contraction are quite transient and for this reason the long lasting and favorable result which often follows needed some investigation. Roskam[4] has found that this long lasting action is probably due to the oxidation of adrenalin to adrenochrome or some closely related substance. This substance is apparently stored normally at the endings of the adrenergic nerves and, in the presence of trauma, it checks bleeding by causing a retraction of severed capillary ends. Those who have read Roskam's excellent monograph on this subject cannot help but place this adrenochrome agent high on the list of drugs favorable for combating postoperative hemorrhage.

The use of Premarin for functional uterine bleeding has caused that drug to be placed into consideration. Its physiologic action is as yet not explained.

While tangible evidence in many instances cannot be provided that any of these drugs is specifically of value, opinions of qualified observers as to the desirability of their use have been favorable. It is probable, however, that many expressed opinions in this field are based on wishful thinking rather than carefully observed results and it is suggested that more thought be given to the physiology of blood clotting by those in the field of otolaryngology so that more precise application may be made of blood clotting aids.

The use of parenteral calcium has nothing to recommend it.

Transfusion of fresh whole blood has been and will probably always remain high on the list, not only for repair value but also because of the variable factors in the clotting mechanism as we know it today. The rationale for the use of stored plasma in the place of whole blood lacks physiologic reasoning, for some of the plasma factors favorable to the clotting of blood are found only in fresh plasma. Unless one has a hemoconcentration due to previous transfusions, which would be unusual in the face of hemorrhage, then it would appear most logical to use fresh whole blood instead of plasma until the cause of the bleeding is identified. It may prove to be a plasma factor and may be one such as the stable factor which is present in both stored and fresh plasma. When it is one of the plasma factors which is deficient, a pint of plasma will add twice as much of the deficient factor as a pint of whole blood. This is specific treatment.

Vascular interruption has always been a nebulous factor in our armamentarium. While we are generally taught that the tying of an external carotid artery will control bleeding from

a unilateral maxillofacial injury, the literature on the subject would tend to prove otherwise. Still, the inaccessability of the anterior and posterior ethmoidal arteries, the internal maxillary artery, and the sphenopalatine artery and the difficulty in determining which of these might be the site of hemorrhage, makes one reticent to speak against external carotid ligation; if one feels it has any chance of success, it should be done regardless of the evidence in the literature.

SUMMARY

Hemorrhage in otolaryngology generally is of nuisance character but on occasion may have fatal consequences. Bleeding and clotting time tests tell us little or nothing regarding a tendency to bleed on the part of any given patient. The use of these tests gives one a false sense of security preceding operations. A careful history, a good blood smear, and a prothombin time and plasma clotting time test when indicated will quickly separate the bleeders from the non-bleeders. These tests also will provide the correct key for the treatment of a known bleeder. When faced with a bleeding problem that is not of blood dyscrasia origin, a systematic plan of attack has been of great value. If one can locate the bleeder, early precise local astringents are in order. If the bleeder cannot be located, then precise, tight packing should be done. Specific treatment for blood dyscrasias can and should be done. Blood clotting aids should be used in the order of their proved physiologic action. In this regard, vitamin K, and adrenochrome agents are of greater importance than Koagamin or Premarin. Early transfusion of whole blood is certainly preferable to the use of stored plasma. Later, plasma may be the agent of choice. External carotid ligation is not always successful in combating hemorrhage from vessels of the head and neck.

I wish to express my sincere appreciation to Harold D. Palmer, M.D. for his invaluable help in the preparation of this paper.

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Emphysema caused by smoking

Thirty-four patients with chronic pulmonary disease characteristic of obstructive emphysema, were studied. Among the groups were 28 males and six females, ranging in age from 50 to 81 years. The evidence presented indicates that in the New England area and in the age group over 50, smoking is the major cause of emphysema, and that the disease is inflammatory rather than degenerative in nature. *Francis C. Lowell, M.D., et al. Chronic Obstructive Pulmonary Emphysema: A Disease of Smokers. Ann. Int. Med. Aug.* 1956.

Injuries of the Lower Urinary Tract

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BECAUSE of the ever increasing rate and number of passenger and pedestrian automobile injuries the number of fractures of the pelvis with associated injuries to the lower urinary tract appears to be rising. Ten per cent of all cases of fractured pelvis produce injury to the urinary bladder or posterior urethra. Injury to the urinary bladder usually is not associated with isolated fractures of the sacrum, coccyx, ilium, or ischium. However, the bladder usually is injured by fractures below the pelvic brim which disrupt the continuity of the pelvic girdle. Examples are lateral crushing injuries or anterior posterior compression such as a child run over by a car.

Injuries to the urinary bladder have been written up far back in early medical literature. However, only since the end of World War I has suprapubic cystostomy become the vital and accepted procedure for treatment of rupture of the bladder. Prior thereto the bladder was simply sutured and urethral catheter drainage was established. The mortality rate was high. Now it has been lessened by improved surgical training, recognition and early diagnosis, refinements in the treatment of shock, and the administration of antibiotics and anesthesia.

Normally the bladder is well protected, when empty, due to it's safe deep location in the bony pelvis surrounded by fascia and a muscular bed, and a bony pelvic girdle. But when distended it is vulnerable to injury. An empty bladder is not immune from injury when bony spicules with force may lacerate the wall.

Bladder injuries can be classified into four different types: contusion, intraperitoneal rupture, extraperitoneal rupture, and combined intra and extraperitoneal rupture. Rupture of the posterior urethra at the prostatic membranous junction also is common in association with injuries to the pelvis. A contusion is simply a non-perforating injury done solely to the wall. Fractures of the pelvis may produce contusion without rupture. These cases usually have gross hematuria but are not associated with the physical findings of ruptured bladder which will be related later.

Let us consider a typical case. An ambulance promptly brings a patient to the hospital from the site of an automobile accident. A great percentage of these accident cases are treated initially by a general surgeon or a general practitioner in smaller communities who are doing their own surgery. It is for this reason that every physician should know the importance of early diagnosis and treatment of rupture of the urinary bladder. The first important finding is shock. There is a marked pallor, the patient's pulse is rapid, and there is a marked fall in blood pressure. A case of this type may be associated with a history of previous alcoholism, and the patient frequently is unconscious and unable to relate any history. If conscious, he will complain of severe lower abdominal pain. If asked to urinate he cannot do so or passes only a small quantity of bloody urine by straining. There is a constant urge to void but the characteristic finding is that the patient fails in his attempt to empty the bladder. There may be blood at the meatus. However, the amount of gross bleeding from the meatus is not an index to the type or degree of injury, since damage to the corpora spongiosum may cause hemorrhage without perforation.

In the extraperitoneal type of rupture, tenderness and pain will be present in the lower abdomen. There will be suprapubic dullness on percussion due to extravasation, or due to a full bladder in the case of rupture of the posterior urethra. If a few hours have passed since the accident a characteristic brawny, full, tender, crepitant feeling will be present in the lower abdomen. If this condition is allowed to persist too long the skin of the lower abdomen along the pelvic border, will show a tense, red appearance due to urinary infiltration. Fever and toxicity will follow. The above findings are charac-

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teristic of extravasation already gone too long, and once a physician has seen and palpated an extravasation he will never forget it. Rectal examination will reveal a mass or a prostate which is floating and out of normal position if there is a rupture at the apex of the prostate.

With intraperitoneal rupture, typical signs of peritonitis develop. There will be generalized abdominal pain and tenderness. There is an ileus, nausea and vomiting follow, bowel sounds are absent, fever and leukocytosis develop.

The extraperitoneal type of bladder rupture usually is associated with fracture of the bony pelvis. It is caused by stress placed upon a fixed portion of the bladder, or perforation by a bony spicule. Usually the rupture is on the anterior or lateral wall close to the bladder neck. In the intraperitoneal type, rupture commonly occurs when there has been a heavy impact to the lower abdomen with a full bladder, hence the important past history of alcoholism. Usually the perforation is on the fundus or posterior wall due to the position of the peritoneal reflection. As a result of irritation from the extravasation of urine onto the peritoneum, the omentum or bowel may temporarily seal the perforation, but the effect of the seal will not hold.

Combined intra and extraperitoneal rupture usually comes from perforating w o u n d s. A crushing injury, fracture of the pubic rami, or symphysis pubis, is commonly associated with a tear of the triangular ligament and rupture of the membranous urethra. Injury above or below the triangular ligament determines the extent of extravasation. It is possible, but not common, to have both.

The most important point that I can stress is promptness in diagnosis. If the case is allowed to linger undiagnosed more than twelve hours the mortality rate increases sharply. Our patient should be carefully placed upon an X-ray table. An important step in diagnosis is cystography. Using the strictest sterile technique the patient should be catheterized. If there is a rupture at the prostatic membranous junction, the catheter usually will not pass to the bladder and the bladder may be distended. In bladder rupture a catheter may reach the bladder but the latter will never be distended. A cystogram should be done using one of the common radiopaque urological dyes such as skiodan or diodrast; 150 to 200 cc. of the dye should be injected into the bladder. If intraperitoneal rupture is present the dye will be seen in a sunburst effect radiating upward into the peritoneum and perhaps be present between the loops of bowel. In an extraperitoneal type of rupture, or rupture at the prostatic membranous junction, dye will accumulate in the fascial layers fanning outward in the pelvis. The so-called tear drop cystogram is due to the presence of extravasated urine and blood clots in the perivesical space. The commonly used dyes for intravenous urography are less irritating to the tissues than sodium iodide solution.

The question arises at this point as to the value of the air cystogram. Some physicians do not use the air cystogram maintaining that air embolism is possible and also that there may be misinterpretation of the X-rays by mistaking air in the peritoneum for bowel shadows. Other physicians do use the air cystogram believing it to be satisfactory. With the patient on his left side, 200 cc. air is injected via urethral catheter. In a characteristic case, an air cystogram of the bladder will be seen on X-ray. In an extraperitoneal type of rupture or rupture of the posterior urethra, air flares out into the fascial planes of the pelvis. In the intraperitoneal type, air will be seen between the intestinal coils and in the subphrenic space.

Some urologists advocate the use of intravenous pyelography at this stage because of the advantage of visualizing the upper urinary tract at the same time. However, if the patient is in shock and his blood pressure is low, there will be poor excretion and therefore poor visualization.

Cystoscopy is not necessary. The patient usually is in poor condition. There is not much to be gained by cystoscopic examination since the bladder cannot hold water, visualization will be poor due to the failure of distention with severe bleeding, and instrumentation may spread infection.

Diagnosis established by instillation and aspiration also is not valid. Some recommend that a given quantity of sterile solution be injected into the bladder and that if the same amount returns by aspiration there is no possibility of rupture. This is not true. The tip of the catheter may be extravesical and instillation and aspiration may be taking place from the perivesical space. As I mentioned previously it also may

be possible that omentum or bowel is tending to temporarily seal an intraperitoneal rupture and for this reason the same amount of fluid may be aspirated after instillation. It is most important that rectal and vaginal examination be done to check for perforation of these structures associated with lower urinary tract injuries.

When the patient has been treated for shock, and a diagnosis established, he should go to surgery immediately. A suprapubic midline incision should be made. The rectus fascia and muscle should be divided in the midline. If the extravasation is extraperitoneal, blood and urine will bulge from beneath the recti muscles. The tissues will have a reddish brown, necrotic appearance, and it is difficult to recognize normal structures due to infiltration. Because it is sometimes difficult to identify the urinary bladder due to the severe impact, and if the urethra is intact, pass a urethral sound through to the bladder and make the incision into the bladder immediately over the sound where it is palpated below the anterior surface of the bladder. With the space of Retzius opened, aspirate blood, clots, and urine. It may be necessary to control bleeding with packing from ruptured blood vessels on the posterior surface of the fractured pubis. Perforation of the bladder should be identified and sutured with #1 chromic catgut. Suprapubic cystostomy should be done, using a large Pezzar catheter, #34-38. Multiple large Penrose drains should be used to drain the space of Retzius and perivesical areas deeply and adequately.

I cannot be too emphatic when I say that suprapubic cystostomy, adequate aspiration, and adequate drainage are the most important phases of treatment of extraperitoneal rupture of the bladder. They are more important than actually suturing the perforation. The Penrose drains should not be moved for seven days, and then only one inch daily until all are completely removed from the surgical wound.

If the rupture is intraperitoneal, all urine and blood should be evacuated from the peritoneum by suction. Examination of the other abdominal viscera for associated injury should be made. The intraperitoneal rupture should be closed in two layers, #0 chromic in the bladder muscle, and #0 chromic in the peritoneal reflection. The peritoneum may be closed without drainage. A suprapubic cystostomy should be done in this case also, using a large Pezzar catheter.

Rupture of the posterior urethra presents a somewhat different type of treatment. The essential point is that at the time of surgery, continuity must be established between the separate fragments of the urethra. In rupture of the posterior urethra the bladder usually is distended and previous catheterizations have been difficult or impossible. I will suggest two well recognized methods of aligning the rupture of the urethra. The first is the Reynolds technique. A Foley catheter is passed through the anterior urethra to the site of the rupture. A simple rubber urethral catheter is passed through the cystostomy into the bladder, and then through the posterior urethra to the site of the rupture. The two ends of the catheters are then tied together with silk or catgut. The Foley catheter is then guided into the bladder by traction upwards on the rubber catheter. The Foley bag may then be inflated within the bladder to align the ruptured urethra. Traction should be placed upon the Foley bag catheter by taping the catheter to the thigh in order to return the displaced prostate and vesical neck back to their normal positions. Another accepted technique, the Davis method, consists of passing a urethral sound through the anterior urethra to the site of the rupture. Another sound is passed through the cystostomy and the posterior urethra from above. The tips of the sounds meet and click at the site of the rupture within the pelvis. The anterior urethral sound is then passed into the bladder by keeping the tips in contact as the posterior urethral sound is withdrawn. The flared end of a rubber catheter is then tied around the tip of the anterior urethral sound within the bladder, and as the latter is removed, the catheter is withdrawn down into the urethra thereby aligning the ruptured urethra. It frequently is impossible to anastomose the proximal and distal segments of the urethra within the pelvis at this point. If possible approximation should be done, suturing the proximal and distal ends together with catgut. The indwelling catheter will act as a splint for healing. Black silk suture should be tied to the tip of the catheter and brought outward through the cystostomy, and anchored

to the skin of the abdomen. You should then proceed as with any other extraperitoneal rupture of the bladder with adequate drainage of the perivesical space and suprapubic cystostomy.

Postoperatively, the patient must be treated with antibiotics, watched and treated for ileus, and electrolyte balance maintained. Suprapubic and urethral catheter drainage should be established until the suprapubic wound is well healed and no urinary drainage comes from above. This usually takes two to four weeks. The suprapubic tube should then be removed, leaving the urethral catheter indwelling. When there is complete closure of the cystostomy the urethral catheter should then be removed. This may take as long as six to eight weeks, depending upon the amount of perivesical drainage. Dilatation of the urethra at the site of the rupture should be started in one week. Postoperative stricture of the urethra is a common sequela. Osteitis pubis also is a distressing complication.

SUMMARY

The mortality rate in rupture of the lower urinary tract is approximately 12 to 20 per cent in the first 12 hours, and 85 to 90 per cent within 48 to 72 hours. Therefore, keen observation of the patient, early diagnosis by physical findings and cystograms, and treatment by drainage and cystostomy must be done early and adequately. If promptly performed, most patients will be saved. Without treatment the mortality rate is 100 per cent. Certainly, with the increasing automobile accident rate, every physician who treats traumatic cases must be aware of these simple points in diagnosis and treatment.

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Prophylactic treatment of syphilis

Prophylactic treatment with penicillin is indicated whenever there is exposure to a person with infectious syphilis. If untreated, many of those exposed develop the disease. A single injection of 2,400,000 units of PAM or benzathine penicillin G will prevent this possibility. Although this is almost universally successful, a three month observation period, which includes periodic serologic and physical examinations, is advisable as a safeguard. *Jules E. Vandow, M.D. and Nathan Sobel, M.D. The Present Status of the Diagnosis and Treatment of Syphilis. New York J. Med. Sept.* 15, 1956.

The chemistry of despair

Modern science recognizes a hate hormone and the physical effects of fear and despair. These emotions bring a definite change in the chemistry of the body. But, on the positive side, this chemistry of despair may be changed to that of hope and enthusiasm. The hate hormone can be neutralized by the new vitamins of faith, kindliness, and a cheerful heart. Doctors know that people with a long term illness often seem to die by degrees. But they also may live by degrees and, if something is lost each day, something also may be gained that will throw the balance in the patient's favor. *Edward L. Bortz, M.D. Mastering Long Term Illness. Geriatrics. Oct.* 1956.

Availability of Hostile Fantasy Related to Overt Behavior

PAUL KANE, PH.D., ELGIN

THE problem of trying to relate an individual's fantasies and his perceptions to how he actually behaves and how he interacts with his manifest environment, has been attacked in a variety of ways. One prominent approach used by a number of investigators has been to study the relationship between overt and covert behavior through the variable of hostility and aggression. Most commonly, one or more projective tests, most frequently the Rorschach and TAT, would be used in a specific manner as a measure of hostile fantasy, and this in turn would be correlated with some defined indications of overt aggression. Our approach differs significantly from previous studies in that an attempt was made through the use of Q-technique to consider an individual's attitudes toward hostile impulses, in addition to the usual method of correlating projective test indications of hostility with certain demonstrated features of overt aggression.

As a point of departure, leading to our main hypothesis, we were in general agreement with Fenichel[2] who wrote: "The conscious impulse to kill, for example, is, through isolation, so far removed from any possible motor expression that there is no chance for the impulse to be materialized, and thus it may safely become conscious. Hence, when the idea becomes conscious, it is stripped of emotion."

We made the assumption then that hostile fantasy can be organized and integrated within the personality in some manner so that the need for an outlet in overt behavior can be averted. Thus the capacity to handle hostile fantasy can be tantamount to a technique of internalization through the process of its being available to the personality for disposition before actual overt behavior becomes necessary. The major hypothesis taken then was that symbolized hostile expression, or hostile fantasy, is inversely related to overtly assaultive, aggressive behavior. This meant that overtly violent subjects were expected to show less hostile fantasy in the test materials, while nonviolent subjects were expected to produce a relatively greater amount of hostile fantasy.

In order to test this hypothesis, data were collected and handled on the basis of two different standpoints. The first approach involved the more traditional use of divergent groups to test differences for significance. Here the total number of 42 subjects examined consisted of two groups each of 21 Joliet-Stateville penitentiary inmates, who were generally comparable in age, intelligence, education, and socio-economic status but who differed largely in certain features of overt behavior. What was termed the hostile group consisted of individuals who had assaulted someone, actually doing harm or seriously threatening it. The majority of these individuals had records of previous aggressive crimes (for example, armed robbery, assault to kill or rob, and murder). In nearly all cases, there were reports on these inmates of fighting, destruction, and insolence within the penitentiary itself. In practically all cases the members of the "hostile" group have demonstrated overt hostile behavior both in their crimes and in their institutional activities. Moreover, in all cases there is recorded evidence of at least two hostile acts, whether the crime plus intramural behavior or two or more hostile criminal acts.

On the other hand, the nonhostile group committed crimes like larceny, burglary, or forgery, in which no one was physically harmed or threatened. In most cases no one but the inmates was directly involved, violation in all these cases being done to property. Furthermore, the adjustment of the nonhostile group within the penitentiary was devoid of any record of fighting, destruction, or marked disobedience and insolence.

All subjects were seen individually and of the projective tests administered, specific mention will be made only of the Rorschach results inas-

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much as this test proved to be most representative and most revealing of the trends distinguishing the hostile and nonhostile groups on the variable of hostile fantasy. All Rorschach records were scored for hostile content according to the De Vos Affective Inferences Scale and according to certain modifications of this scale, designed to accentuate the dynamic content under consideration. In this scale, Rorschach responses were scored as hostile for both direct and indirect manifestations of aggression. For example, perceptions involving fighting, conflict, argument, weapons, knives, and derogation and depreciation of figures, were scored for hostility.

The most striking finding on the Rorschach was quite contrary to our hypothesis. Instead of finding an inverse relationship between hostile fantasy and overt aggressive behavior, we found that the most aggressively acting out individuals also had significantly more hostile fantasy on the Rorschach. This was not only statistically significant but was also qualitatively impressive as the records with the most openly violent and directly hostile responses were those of overtly assaultive individuals. Three such records by overtly violent inmates can be cited briefly.

The first case, quick in giving the somewhat moderate number of 21 responses, nevertheless produced hostile Rorschach responses like, "looks like they got in a fight, all that blood spilt over," and, "looks like two men fighting over something or other, the clothes is all tore up; looks like their heads were bleeding." Out of 51 responses, the second case had 15 that were scored for hostility, ranging from such directness as "two shadowy figures dueling with knives in their hands; seem to be kneeling in blood," to less openly violent responses like, "huge nose, jaw receding; face of a simpleton, idiot, imbecile; don't look too bright," and "he looks more or less vicious." Nineteen of 87 responses in the third case were suggestive of a degree of inner tension that seemingly could readily explode into outbursts reminiscent of some of his responses, "an explosion of hot gases," "an earthquake erupting," "an army submachine gun in rapid fire," and, "fragments of metal scattering after an explosion." The Rorschach hostility of these three overtly aggressive cases just cited had no match at all either for intensity or frequency in the non-hostile group.

While the Rorschach finding appears to refute our hypothesis, the Q-technique data now to be mentioned actually helps to clarify it in relation to the underlying theory.

The second approach to clarifying our hypothesis involved the use of Stephenson's Q-technique, a methodology for the study of an individual case. Six subjects, three representative ones from both the hostile and nonhostile groups, sorted 72 statements which had been constructed in line with the theory under investigation. Statements designed to tap hostile fantasy were of this nature: "My feelings come out easily; when someone bothers me or makes me mad, I let them know about it. . . . . I don't like everyone I know and sometimes I can't help showing it, though I don't mean to. . . . .Sometimes I feel as if I must injure or damage something or someone, and sometimes I do." Each subject did eight separate sortings of the 72 statements into a quasi-normal curve distribution, according to different conditions of instruction. Besides the more usual instructions that refer directly to the self, several conditions of instruction relate to the penitentiary environment, including some of the commonly used terminology. A few of the eight conditions of instruction according to which the 72 statements were sorted, follow: How do you feel now or how do you usually feel? How do you feel when things aren't going well for you, everything seems wrong and going against you, and you're really mad and bothered about things? How do you feel the "screws" (prison guards and officials) would look upon you? How do you feel "bug doctors" (psychiatrists, sociologists, psychologists, etc.) would look upon you?

The statements thus variously sorted were correlated and factor analytic procedures were carried out so that attention could be focused on the most meaningful and discriminating statements characteristic of each subject. Interpreting the most differentiating statements, we found that the overtly hostile subjects were prone to present a highly conventional, stereotyped front; one in which the socially acceptable virtues and character traits are lauded, hostility denied, and the home background regarded so highly despite recorded disruptive features as to be suggestive of a strong defensive position. Admission of hostile, impetuous feelings emerged to any notable

extent only when presenting one's self through the eyes of some one else, and invariably some one like the penitentiary officials and staff who are presumably familiar with the inmates' history. There is then a noteworthy tendency for the hostile individuals to try to present a positive, commendable self directly and to admit to hostility, impulsiveness, and shortcomings generally, in a projective manner through a presumed external viewpoint. The nonhostile cases, on the other hand, were not so rigid in separating their direct self-perceptions from their views as to how others might perceive them. There was a greater tendency in these cases to share or integrate their own viewpoints with those of others. Hostility and impulsiveness were more frequently admitted directly, suggesting less defensiveness in this area.

As this finding tended to support our main postulation that overtly aggressive individuals would have hostile fantasy less readily available to them for internal handling, how can we reconcile this with the Rorschach finding of a direct relationship between violent overt behavior and hostile fantasy? It would seem that an error was made in assuming that what has been called hostile fantasy or symbolized hostile expression implied a technique of internalization. The implication was that perceiving hostility in projective tests indicated that such fantasies were in some way available to the individual for internal control and disposition; this is clearly not so. When an individual perceives what is considered "hostility" on the projective tests, we cannot from that fact alone determine to what extent such hostility is actually acceptable to him and therefore to what extent it is available for internal integration. Only by attending to an individual's attitudes and admissions toward his own feelings, have we been able to clarify issues which would have been partly misinterpreted and incompletely understood had conclusions been drawn only upon inferences from a subject's projective test productions and no consideration given to how the subject himself may feel more directly about some of the matters at issue. Clearly, what is termed levels of personality, must be considered in any investigation of an individual's apperceptive responses to stimuli, and certainly such levels must be noted in response to test materials in any systematic study of important personality variables.

In integrating the varied disclosures about overtly hostile individuals as compared to nonhostile subjects, we see that the hostile individual is significantly more prone to have hostile fantasies, particularly fantasies that are relatively direct and unmodified in their aggression. However, this would appear to be more symptomatic, more revealing of an inner condition, and does not indicate his capacity to deal internally with this hostility. The aggressive individual is more likely to deny his hostility, to project it onto others, or admit it indirectly through the eyes of others but not too directly to himself. Hostility is therefore less readily, less consistently available to him for internal control and disposition. The nonhostile person, in contrast, is somewhat better integrated, less disturbed, and more secure so that he can admit to failings and shortcomings to a greater degree than the hostile person who almost desperately must defend what little support he has. Beneath the hostile person's periodic outbursts would appear to be a sense of isolation, a passive, dependent person too unsure of himself to accept feelings and impulses that may pose even a bigger threat to him—a greater sense of isolation.

Elgin State Hospital.

Based upon a dissertation submitted to the Department of Psychology of the University of Chicago in partial fulfillment of the Ph.D. degree requirements. Appreciation is particularly expressed to Dr. Wm. Stephenson, the thesis sponsor, and also to committee members, Dr. Samuel J. Beck and Dr. John M. Butler. The author, however, assumes sole responsibility for this condensation of the more complete work.

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Reflex Vasodilatation Measured with Radioisotopes

WILLIAM H. MYERS, M.D., AND MORRIS T. FRIEDELL, M.D., F.A.C.S, CHICAGO

IN the care of patients with certain peripheral vascular diseases, lumbar sympathectomy still remains a valuable method of treatment. The selection of cases which will be benefited by the procedure is most important and avoids operations that would be time consuming, useless, and in some instances actually dangerous.

In a previous preliminary report[1] one of us (M.T.F.) pointed out the value of the use of radioactive iodinated serum albumin (RISA®)* in evaluating peripheral blood flow. Others[2] also have used it to advantage. This method is one of the few allowing direct measurements of peripheral blood flow which are reproducible.

The types of cases under consideration are those with arterial occlusive diseases of varying severity up to and including frank gangrene. Successful treatment depends upon increase of blood flow to the extremities by any means available, including drugs, nerve blocks or surgery.

The use of RISA and lumbar sympathetic blocks, as pointed out previously, is a valuable test for predicting the response to treatment, particularly lumbar sympathectomy. In this, as in all tests, any simplification that will give necessary information, save time and expense, and give comfort, would be of great practical value. The purpose of this report is to outline such a simplification or modification of the test.

The apparatus used consisted of a scintillation counter, a count rate computer, and a graphic recorder. Subjects were tested in a quiet, draft-free room lying comfortably on an examining table. The studies were made on the lower extremity with the foot resting against the scintillation counter. One hundred microcuries were injected rapidly into the antecubital vein; the time of injection was marked on the recording paper. After observing the basic recording, heat was applied to the abdomen of each patient for 20 minutes. Usually a heating pad at 130°F. was used; however, a hot-water bag would serve equally well, except that the temperature would not be as constant. The graphic tracing was then resumed. Any increase in counts per minute (CPM) would be due to reflex vasodilatation and the height of rise would give an index of the ability of the limb to respond to other methods of vasodilatation, particularly lumbar sympathectomy.

All cases of arterial occlusive disease coming to our attention are now being studied by this method prior to surgery. The following case history will serve to illustrate the usefulness of the test.

L. B., a 39 year old white male accountant was admitted to Cook County hospital on April 27, 1956 with complaint of an open ulcer of the left ankle, present for the previous 10 months. The patient stated that during the previous June, without known cause, the ulcer developed and when it failed to heal, he sought treatment. He was given many forms of therapy during this time but only Priscoline® and bed rest were of any value in decreasing the size of the ulcer. It again enlarged, however, when he became ambulatory. Associated with this was a sensation of burning at the site of the ulcer, continuously and to such an extent that he could not allow anything to come into contact with the area, such as dressings or bed sheets.

Past history revealed circulatory disturbances of the lower extremities since childhood. He stated his feet were very sensitive to cold and that he had been completely unable to participate in sports because of muscle cramps and legs becoming tired quickly. However, prior to 1940, he could walk well without claudication. At this time he received a medical discharge from the army because of difficulty with his legs. In 1942 he had an ingrown toenail removed from his right great toe, the operative site failed to heal, apparently became gangrenous, and the toe was amputated. A diagnosis of Buerger's disease was made. He was treated with intermittent pressure without relief, and sympathetic blocks, which helped for a short time only. Sympathectomy was not performed nor suggested. Because of failure of the amputation to heal, even with several revisions, another amputation was performed, this time

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*Obtained from the Abbott Laboratories, North Chicago, Illinois.

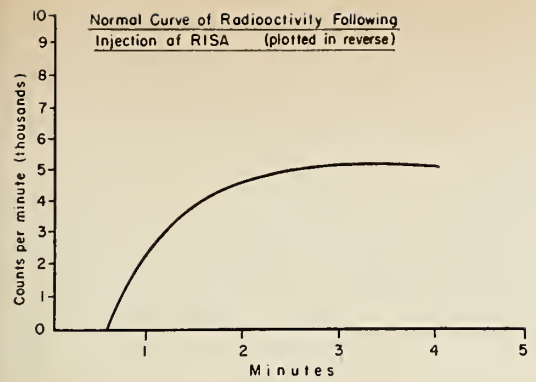


Figure 1

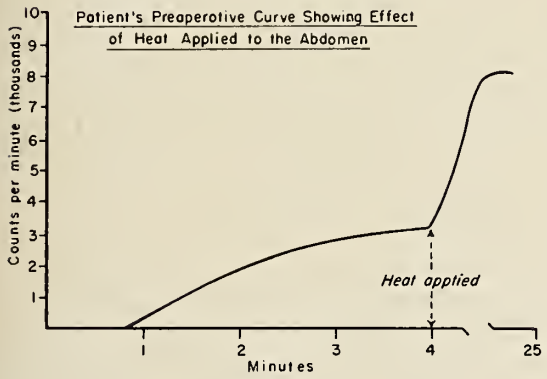


Figure 2

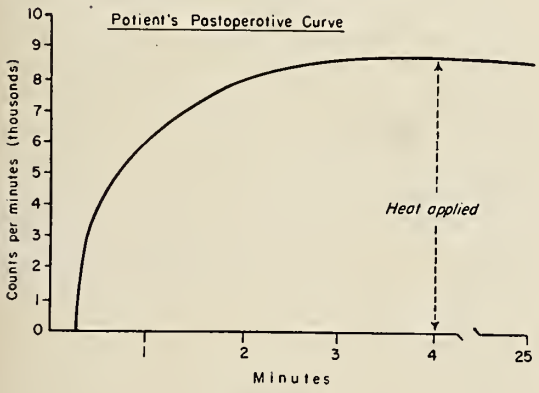


Figure 3

stump required several revisions and with a cross-leg skin flap in 1949 finally became closed. (The healing of the donor site on the calf of the left leg was noted to be very slow). A prosthesis had been fitted earlier and the man returned to work in 1950. From that time to the present admission he developed increasing difficulty with the left leg; claudication, night pain somewhat decreased by dependency, increase of pain with application of heat, painful ulceration, and pain of the calf and knee even at rest. It was in this condition that he was first seen by us. Further inquiry revealed that the man had smoked moderately from age 20 to two years prior to admission. Alcohol ingestion, except occasionally, was denied. His parents were of English extraction and familial history of similar difficulty was not obtained. The patient denied impotence.

Physical findings were essentially limited to the lower extremities:

Skin: dry, roughened, and scaly with reduced temperature.

Right leg: amputated about 6 inches below knee with evidence of the flat graft, healed.

Left leg: small ulcerated lesion just above the lateral malleolus; with irregular edges, flat necrotic base, 2 cm. in diameter; no pulse was palpable in the foot, leg, or in the region of the external iliacs or aortic bifurcation; no evidence of acute or chronic venous disease.

Laboratory: Hb. 89%, WBC 8,750, NPN 27, cholesterol 174. Urine-negative.

Chest X-ray was normal.

The patient was treated with Papaverine®, gr. 1-½ t.i.d., multiple vitamins, high protein diet, bed rest, moist applications to the open ulcer, penicillin, and Demerol® in doses sufficient to control pain of the extremity. An aortogram was atempted but a free flow of blood was not obtained and on injection of a very small amount of radio-opaque dye, severe pain was experienced in the leg and the examination was discontinued. Lumbar sympathetic blocks were performed on several occasions with partial relief for as long as six hours.

He was then tested with RISA in the manner described. Results of the testing are shown in Figure 2 (During the testing he was able to compare relief obtained by block and by heat applied to the abdomen and felt that he received more relief from the heat). On May 16, 1956 a lumbar sympathectomy was performed under general anesthesia and ganglia 2, 3, and 4 were removed. His postoperative course was uneventful. The results of surgery were gratifying to the patient who stated that his pain had been completely relieved. The leg felt warmer and was in no way sensitive to the touch. He could walk an unlimited distance without claudication. Objectively, the limb was dry, warmer, and the ulcer healed quickly. Results of the follow-up testing with RISA are shown in Figure 3. Biopsy of the abdominal muscles taken at the time of surgery was reported as normal. The patient refused biopsy of the muscles of the leg because he felt healing would be prolonged. On May 30, 1956 he was first discharged free of complaints and returned to work for the first time in more than a year.

COMMENT

Figure 1 shows the curve obtained in a person with normal peripheral vessels. The circulation time is about 35 seconds and there is a rapid rise to a plateau over a period of 2 to 4 minutes. It will be noted that the patient's pre-operative curve (Figure 2) has a prolonged circulation time, and a prolonged rise to a plateau which is considerably below that of the normal individual. The further rise of the curve following lumbar block and heat to the abdomen also is shown.

The curve following surgery (Figure 3) shows

a decrease in circulation time and a more rapid rise to an apparently normal plateau. The lack of response to heat again applied to the abdomen indicates that the maximum vasodilation has been achieved.

SUMMARY

A method of measuring peripheral blood flow with the use of radioactive iodinated serum albumin (RISA) and a scintillation counter is discussed. A simple modification of this procedure, consisting of heat application to the subject's abdomen, also is shown. This test permits prediction of the response to sympathectomy. A case report, with graphic tracings, is included to further illustrate its practical application.

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Religion and psychiatry

Freud, the founding father of psychotherapy, claimed he was making a contribution to science and held that psychoanalysis had no relationship to philosophy. He never recognized that he had a philosophy of scientific materialism. As Freud developed the new field he evoked also (although not always explicitly) a philosophy of life. This philosophy denied God, human freedom, and the reality of religion. (Not all psychiatrists share this viewpoint. I wish to make it plain that in this section I am dealing with specific psychiatrists, not with the whole field of psychiatry.) Later, Erich Fromm, J.C. Flugel, Harry Stack Sullivan, and Karen Horney, like Freud, added their own viewpoints to those of Freud — viewpoints that contradicted the doctrines of Christianity.

The general principles of Freud and his followers is reductive. Everything — God, man, Holy Communion, which Christianity had ascribed to or related to a supernatural order — is reduced to the natural order. As Karl Stern put it: "To a modern astronomer, the earth is nothing but an insignificant speck in the galaxy; to the biologist, man is nothing but some chance product of an evolutional process which has no transcendental meaning; to a dialectical materialist, cultural achievements are nothing but by-products of the economic struggle."

By this process, Freud defined God as nothing but a father image and Fromm called upon man "to recognize that there is no power transcending him." Man is reduced to the sum total of his biologic inheritance and his psychosociologic conditioning. The end of life is life itself. Man can make the good life on earth by himself; indeed, there is nothing beyond to help him. As for ethics, the followers of Freud maintain that that is good which satisfies man. *Man For Himself* is not only a book title; it is Fromm's whole philosophy of life. Here then is a new philosophy. For it, some Freudian psychiatrists claimed a basis and a support in modern science. Can psychiatry prove that there is nothing beyond man; that real freedom does not exist? Obviously not. What we have here then is not a medical science but speculative philosophy on a pseudoscientific basis — a philosophy that contradicts Christianity. Fromm's god, man, is — by my book — a creature not a god; and he who worships the creature instead of God is an idolater. The devout Jew and Christian will not buy this "nothing but man" religion. For it to be palmed off as medical science is a discredit to the medical profession. *The Rev. Das Kelley Barnett, Th.D., Religion and Medicine — Allies or Adversaries? GP, Sept.* 1956.

Drug Reactions

Leonard H. Harris, M.D., Peoria

I WOULD like to remind you that many of our commonly used drugs can cause in addition to skin eruptions, several types of systemic reactions. Anaphylaxis, shock, serum sickness, asthma and even death have been seen following the ingestion or the injection of many common drugs. This list should include aspirin, iodides, local anesthetics, organ extracts including insulin, liver extract and ACTH, penicillin, pollen extracts, horse serum, thiamine, and now possibly P.A.S.

ASPIRIN

Although the incidence of aspirin sensitivity is fortunately low, its allergic manifestations are almost invariably severe. Violent sudden paroxysms of asthma or shock within a few minutes of the taking of an aspirin tablet is the typical allergic reaction to aspirin. Specific skin reactions to aspirin have not been obtained on known sensitive subjects. Feinberg[2] has, however demonstrated the antigenticity of aspirin in guinea pigs passively sensitized by aspirin-sensitive human serum when challenged with heterologous aspirin-protein conjugate. Most aspirin sensitive people are chronic asthmatics of the intrinsic type, usually completely skin test negative. Skin testing with aspirin is valueless and dangerous. One is wise to believe the patient who says he does not tolerate aspirin.

INSULIN

In the past 10-20 years reactions to insulin have been on the decline while reactions to liver extract have steadily increased. The commonest manifestations of allergy to insulin are urticaria and unusual local swellings. Shock or asthma are rare; fatalities have not been reported.

The specific protein responsible for insulin reactions varies from patient to patient. This seems to hold true for liver sensitivity and ACTH sensitivity as well and explains the long standing disagreement as to whether insulin reaction (and liver reactions) are organ specific or species specific. Most insulin reactions are organ specific, that is, due to the crystalline insulin itself and not to the source animal. Species sensitivity occurs less commonly and this group benefits from changing from pork to beef insulin.

Jorpes[3] in 1949 showed that insulin was less antigenic after being recrystallized 6 or 7 times and then could be tolerated by most insulin-sensitive persons. Dolger[4] subsequently claimed similar good results by immersing the insulin vial in boiling water for 30 minutes. This may be done with regular or crystalline insulin but not Protamine or globin products.

LIVER EXTRACT

According to Alexander[1] the incidence of reactions to liver extract has increased in the past 20 years from less than 1% to 20-25%. Urticaria or shock occurs after many treatments and usually during a second course of treatment.

There is disagreement as to whether liver reactions are due to organ or species sensitivity. Leo Criep[5] has good immunologic evidence that the case he studied was due to organ specificity. Rynes[6] on the other hand demonstrated sensitivity to liver extracts as well as muscle tissue of pork, beef and lamb.

Rapid desensitization with or without antihistaminic drugs usually can be carried out successfully in most cases of liver sensitivity.

ACTH

I need not say that corticotropin (ACTH) is a valuable agent in the relief of drug sensitivity, bronchial asthma, and urticaria. But ACTH is a protein substance, capable of inducing sensitivity. The incidence of reactions to ACTH at present is around 3 to 5% in large series of cases. Anaphylactic shock with collapse, asthma as well as allergic dermatitis and urticaria have been reported, more often after interrupted series of treatments. Positive skin tests to ACTH were

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Presented before the Section on Allergy, 115th Annual Meeting, Illinois State Medical Society, Chicago May 19, 1955.

obtained in some of the reported cases. Schulman reported 5 cases of the serum sickness type, all of whom were found sensitive to the animal source. Feinberg's[7] case of shock and asthma following ACTH appeared to be due to the hormone itself and not to the animal source.

THIAMINE HYDROCHLORIDE

Thiamine hydrochloride deserves a few words of comment. Considerable untoward reactions have been reported. Kaltz[8] and Jaros[9] suggest that the effect of thiamine more closely resembles the reactions due to acetylcholine than to allergy. Others have pointed out some of the usual signs of hypersensitivity, but the evidence is not too conclusive. There have been several reports of sudden shock, collapse, unconsciousness and at least one report of death following thiamine parenterally. Urticaria is the most common reaction.

It is important to note that in thiamine reactions, the antihistamines are ineffective. Epinephrine fortunately has a prompt effect.

PARA-AMINO SALICYLIC ACID

Reactions occur in at least 2% of patients given P. A. S. Most reactions occur after 12 days of high dose therapy. (usually 12 grams daily). The reactions may be:

1. Macopapular dermatitis with weeping and itching in milder cases.
2. Exfoliative dermatitis may follow if the cause is overlooked and its use continued.
3. Chills, high fever with severe prostration and possible liver damage have been observed due to P.A.S. The usual dose of 12 gm./da should be stopped at once if any of these signs appear. Workers in TB institutions[10] have observed recurrences of fever and chills upon readministration of as little as 3 grains.
4. Thrombocytopenia, bone marrow depression and liver damage have been recorded due to P.A.S. therapy when the drug is continued despite the skin eruption.

Crofton claims he has successfully desensitized a large number of patients. But in view of the severity of the possible reactions this hardly seems advisable.

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Death from chicken pox

The attention of physicians is called to fatalities from chicken pox that have been reported recently by physicians in various parts of the country. Chicken pox usually is a mild disease and deaths from it are rare. Investigation of the cases in which fatalities occurred indicated that the same factor was present in all of them. All of the children had been under treatment with cortisone or ACTH for some pre-existing disease. Since there is evidence that cortisone has an untoward effect on bacterial and viral infections, the relationship between the administration of cortisone or ACTH and the fatalities in chicken pox appears to be a causal one. Physicians are cautioned, therefore, to reduce rapidly and then discontinue the use of cortisone or ACTH in any child under such treatment who develops or is intimately exposed to a case of chicken pox. *Health Department News, New York Med. July* 5, 1956.

EDITORIALS

Pen-knife surgery

The successful resuscitation of a physician who died from a heart attack was reported by Claude S. Beck and associates.[1] The victim collapsed on the steps of the hospital and was rushed to the emergency operating room. There were no heart sounds and ordinarily, the patient would have been pronounced dead.

But one of the nation's most experienced resuscitation teams was standing by. The physician's chest was opened between the fourth and fifth ribs and his heart was squeezed intermittently against the sternum. Oxygen was administered initially by mask and replaced later by an intratracheal tube. Defibrillation was started as soon as the machine was put in order.

The patient made an uneventful recovery, demonstrating that the death factor in coronary artery disease often is small and reversible. According to Beck: "It is comparable to turning the ignition switch in an automobile or to stopping and starting the pendulum of a clock. The heart wants to beat and often it needs only a second chance."

This led to the concept of the trigger mechanism as the cause of death in coronary occlusion.[2] The trigger zone is an ischemic area of myocardium, lacking oxygen and sending out electrical impulses which in turn destroy the normal mechanism. Unless the ischemic area receives blood (oxygen) the heart becomes electrically unstable and goes into ventricular fibrillation and asystole, followed by sudden death. Death is mechanical and is not due to muscle failure.

Beck believes that 90 per cent of all coronary deaths are due to electrical instability; one-third occur without muscle damage; in the remainder, muscle destruction is not great and the heart will keep on beating if given the stimulus.

Resuscitation must be started immediately because permanent brain damage is said to occur after five minutes of asystole. The procedure has been done successfully on many occasions in the operating room. Beck's experience was the first to be reported outside the operating room but his enthusiasm does not stop there. He suggests that teams be trained to take over when a patient dies from an acute heart attack.

He says, "Any intelligent man or woman can be taught to do resuscitation. A medical or nursing degree is not a prerequisite to learn resuscitation nor is it impossible to provide resuscitation kits to be opened for the emergency; these could be located in selected areas." By "selected areas" he means the golf course, office, or home.

Beck is quoted in the October, 1956, issue of Coronet as saying that in the future, mobile resuscitation kits, with squads trained to use them, will become standard equipment in the

1. Beck, Claude S. et al.: Fatal Heart Attack and Successful Fibrillation, J.A.M.A. 161:434-436 (June 2) 1956.
2. Brofman, Bernald L. et al.: Electric Instability of the Heart, Circulation 13:161-177 (Feb.) 1956.

offices of hotel physicians, in community first aid station, in factories, and in business health centers. The members of the team will need a two day postgraduate course.

The plan has been put into action and several reports have appeared. A Western surgeon attending a Saturday night party collapsed in the living room of his host. Two internists were present and when they were unable to hear heart sounds, they opened the patient's chest with a penknife and began massaging his heart. The pulmotor squad was called and the physician was revived, only to succumb two days later of a second occlusion.

The problem is far from settled because we have no statistics on how frequently the organ beats spontaneously after asystole. Resumption of the beat has occurred on many occasions and this fact will be used by the more conservative physician as an argument against cardiac massage. Unfortunately, there is no time to procrastinate because the procedure must be done within five minutes, to be successful. It presents a serious problem in judgment because a life is at stake.

Hiram T. Langston recognizes the emergency in the operating room but is leery about training nonmedical personnel to wield a penknife at will. He says: "To assume that cardiac arrest or ventricular fibrillation has occurred because of sudden collapse and a pulseless state suggesting death, and to proceed through immediate thoractomy (four minutes generally is given as the period of grace) to cardiac massage away from all manner of resuscitative equipment is a prostitution of this concept.

"The heart may well be restarted by such a maneuver (if it be truly stopped) but oxygen —that commodity so essential to resuscitation and, for that matter, to life on this earth—is in short supply. An intact chest cage that is manually operated and takes in room air probably can provide more oxygen than can be supplied by mouth to mouth pressure breaching of used air forced into a chest that has been opened.

"I am not against an aggressive attitude in the eradication of disease or the preservation of life and I will subscribe to hastily done thoracotomy for cardiac massage if a proper indication exists. But in the absence of equipment for accurate diagnosis or adequate resuscitation, I question its propriety.

"I cringe, in fact, at the appalling prospects of lay people (firemen, policemen, or golf caddies) equipped with do-it-yourself kits for cardiac arrest being willing to 'save the life' of any who may fall by the wayside. These tired and fainting people just might not be dead.

"If I be the one to fall and am seemingly dead, please stretch me out, loosen my clothing, and fan me. Should I be truly dead, 'tis just as well. But should I not be dead, my recovery will not have been hindered. I for one am quite convinced that should I be otherwise qualified, those Pearly Gates will swing out to admit me just as easily without a hastily done incision into my chest as with one."

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Hospital costs

The American Hospital Association announced that room rates in United States general hospitals had risen about 6 per cent in the past year.

In compiling its annual survey of hospital rates, the Association questioned short-term general hospitals in the United States and Canada. The results were based on 2,835 completed questionnaires. The tabulation did not include federal hospitals and large municipal hospitals because their rates are not comparable with those of most general hospitals.

Room rates cover the patient's bill for routine hospital services such as the hospital room, all meals on general and special diets, general nursing service, medical records, and routine housekeeping. In the computation of average rates, all rates were given equal weight regardless of the number of beds in the hospital, or the volume of service provided.

United States averages for the various types of rooms were: single rooms, $15.19, two-bed rooms, $12.16, and multibed rooms, $10.58. A year ago the AHA reported averages of $14.14, $11.51, and $9.84 respectively for these types of accommodation. This represented an increase in rates for single room accommodations of 7.4 per cent, two-bed rooms, 5.6 per cent, and multibed rooms, 5.8 per cent. The increases reflect the increase in hospital costs shown in other American Hospital Association statistics during recent years.

The Association's rate survey said, "For all types of room the highest averages by region were from the Pacific states, which showed averages of $20.32, $17.05 and $15.78 for single, two-bed and multibed rooms, respectively." This region includes Washington, Oregon, and California. The survey noted that the "lowest average rates were found in the West South Central region—$11.53 for single room, $8.96 for two-bed room, and $7.49 for multibed rooms." In this region are Arkansas, Louisiana, Oklahoma, and Texas.

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Millions for research

Medical research has never had it so good. Millions of dollars are available from government, foundations, industry, associations, and philanthropies. Some of these funds are used for research; others, for equipment and buildings. Collectively. it is bound to do good but it should not be used indiscriminately.

We will never know how much of this money is wasted. It is easy to get physicians and scientists to work on projects for which money is available. But the best results are obtained when the research is done by someone who is interested or who wants to find the answer to a specific problem. These dedicated men and women were responsible for the great discoveries of the past. They were properly motivated and this attitude is just as important now as it was in previous centuries.

Of equal importance is that grants be given to those best qualified to tackle a specific problem rather than as a source of matching income to install expensive equipment or to build another story on a hospital, medical center, or an association building.

The time has come to take a firmer stand, lest research get out of hand. Careless or useless work in this field may topple research from its pedestal. This would be a blow to science.

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Blue Shield acts to meet new challenges

Ten years ago 45 struggling local Blue Shield Plans had a combined enrollment of less than 2 million people. Today, 73 Blue Shield Plans cover some 38 million; and if their present rate of growth is maintained, these Plans will pass the 40 million mark in enrollment during 1957.

Several factors have conspired in recent years to alter and complicate the basic problems of Blue Shield enrollments. For one thing, most of the windfall apples have fallen off the tree, and enrollment men are having to climb ever higher in the tree to fill their baskets. Most local "blue chip" industrial groups have long since been enrolled by Blue Shield or some other agency, and the remaining local prospects are predominantly small groups: the self-employed and rural dwellers.

Another vital new factor has been introduced by the tremendous growth of new industrial giants resulting from corporate mergers, and the concomitant tendency of labor unions to negotiate welfare benefits on a national scale. These big corporations and unions are demanding nation-wide hospital and medical care programs, offering at least the same scope of benefits for their workers in all parts of the country.

Blue Shield is an association of strictly autonomous local Plans, having similar purposes, but offering a considerable variety of specific benefits. The Constitution of Blue Shield Medical Care Plans recognizes that "state and local medical care plans should be autonomous in their operations so that the needs, facilities, resources, and practices of their respective areas can be given due consideration, but that the health and welfare of the public is advanced by the co-ordination of methods, coverage, operations and actuarial data."

The Plans have sought, by voluntary agreement, to co-ordinate their efforts and to develop a basic program which each local Plan may offer the members of inter-Plan groups within their local Plan areas.

Without sacrificing local independence, more than three-fourths of the Plans have recently reached agreement on a standard scope of Blue Shield benefits, all or any of which each Plan will make available to any group of subscribers desiring this pattern of benefits. Nearly all the other Plans have promised to "go along" in the near future. While this degree of co-ordination of benefits (in terms of covered services) has been found necessary to meet Blue Shield's enrollment challenge, each Plan will still make payments to physicians according to its locally

negotiated schedules and will calculate its own subscription rates.

This significant achievemeent of Blue Shield shows its ability to meet new conditions and proves the capacity of medicine's voluntary prepayment movement to solve whatever problems it may encounter.

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A.M.E.F. had record-breaking year

The American Medical Education Foundation has just completed its fifth year of operation with a record total of $1,072,717 in contributions.

This figure represents a 41 per cent increase over last year's total of $757,163.29 with the $125,000 grant to the Foundation made by the American Medical Association at the Clinical Meeting in Seattle, or an increase of 25.1 per cent not considering the added generosity of the A.M.A.

The $125,000 was in addition to an original gift of $100,000 voted by the Board of Trustees earlier in the year.

The success of the Foundation can be attributed directly to the hard work and foresighted planning of the State Chairmen who have given so much of their energies to AMEF in 1956. Because of these efforts, we have every reason to believe that 1957 will be an even greater year.

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Injuries are major cause of death in army

About three-quarters of all deaths in the Army are due to injury, according to Lt. Col. Herschel E. Griffin, Medical Corps, Chief, Communicable Disease Branch, Office of the Army Surgeon General, speaking at the Army Preventive Medicine and Laboratory Officers Conference in Washington, D. C., 15 January, 1957.

Colonel Griffin was one of 30 speakers scheduled for the week-long Conference held at the Walter Reed Institute of Research, Walter Reed Army Medical Center. Key preventive medicine and laboratory officers from the six Continental United States Army areas and major overseas commands were briefed on recent development in the promotion of health and the prevention of disease.

In reviewing the causes of noneffectiveness in the Army, Colonel Griffin emphasized that the overwhelming cause of death in the Army, as in civilian life, is injury. Roughly one half of these injuries, he said, are accounted for by automobile accidents, most of which occur during off duty hours.

The Army has a two-pronged approach to the problem of injury. It tries to learn, through research and development, what the killing agent is when death occurs from accidents; this information has resulted in improvements in the design of motor vehicles. And the Army tries, through a study of road conditions and traffic situations, to find out who was hurt and why. Colonel Griffin pointed out that medical, safety, police and engineering personnel are co-operating in these efforts.

Through its preventive medicine program the Army has been very successful in its fight against communicable disease, Colonel Griffin said. Hospitalization, sick days, and death rates have been cut in half, a comparison of the statistics from 1942-1945 with those of 1953-1955 shows.

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Illinois medical history

The matter of licensure of physicians has evoked considerable study and discussion at various times since territorial days. Recently the Council created a committee on Medical Licensure to study the question.

A short review of our various medical practice acts might be of interest, and much of this information is found in Chapter XXV of Vol. II of the "History of Medical Practice in Illinois."

In 1817 the Territorial Assembly, of which Dr. George Fisher of Kaskaskia was speaker, adopted the following resolution: "Whereas well regulated medical societies have been found to contribute to the diffusion of true science and particularly to knowledge of the healing art, therefore, for the purpose of regulating the practice of physic and surgery, this law is enacted."

Two districts were formed: one east and one west of the third principal meridian. The ordained duties of the members were to examine students and give diplomas, charging $10.00 therefor. Apparently not much attention was paid to that law.

In 1819 the state's first General Assembly passed "An act for the establishment of medical societies." This was a tough and comprehensive law. It divided the state into four medical districts and in each there was to be a "board of physicians." It was the duty of each and every physician in such districts to attend meetings. Failure to do so without sufficient excuse made them liable to a fine. The Boards were to collect $10.00 for each diploma issued; to see to it that those not complying with the provisions of the Act were disqualified from collecting debts from their practice; and to see that reports of births, deaths, and diseases were transmitted to and published in some newspaper. Finally, they were to review the bills rendered by physicians for exorbitant charges, making necessary adjustments and returning such surplus as might be unreasonably made. Thus was set up one of the first grievance committees in the United States. The law was repealed by the following legislature in 1821.

In 1825 another bill was passed and repealed by the next legislature.

Over the next half century the profession as individuals and, after 1840, through the state and other medical societies, sought legislation to protect the people of Illinois from ignorant and dishonest practitioners.

Finally in 1877 the legislature passed two bills, one known as the State Board of Health Act and the other as the Medical Practice Act. The legislature evidently still viewed the matter with a somewhat jaundiced eye. It made the Board of Health responsible for the administration of both laws and gave it only $5,000 to do the job over the next biennium.

The Board, organized July 12, 1877, was the beginning of our present highly effective Illinois Department of Public Health. Its first annual report covering the period to December 31, 1878 estimated that when the Act went into effect about 3,600 nongraduates were practicing medicine in Illinois. About 1,400 had quit or left the state.

In 1893, at its annual meeting, the Society was told that the State Board of Health was still granting licenses to men who failed to pass their college exams.

The Civil Administrative Code in 1917 divided the Board into two departments one to deal with sanitary and hygienic work; the other, to deal with licensure not only of physicians but also of all other professions that require licenses.

The present medical practice act was approved June 30, 1923 and has been subjected to a number of amendments (1923, 1945, 1949, and 1951).

J. H. H.

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Creed for sufferers

The following "Creed for those who have Suffered" was written by an anonymous Confederate soldier and appeared in the November 1956 issue of the Maine Medical Association:

I asked God for strength, that I might achieve.
I was made weak, that I might learn humbly to obey.

I asked for health, that I might do greater things.
I was given infirmity, that I might do better things.

I asked for riches, that I might be happy.
I was given poverty, that I might be wise.

I asked for power, that I might have the praise of men.
I was given weakness, that I might feel the need of God.

I asked for all things, that I might enjoy life.
I was given life, that I might enjoy all things.

I got nothing that I asked for,
But everything I had hoped for.

Almost despite myself, my unspoken prayers were answered.
I among all men, most richly blessed!

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MEDICAL ECONOMICS



"Out of the Cauldron"

C. Elliott Bell, M.D., Decatur

HAVE you ever heard of a "Paid-up" Health Insurance Policy? Neither had we! Yet, there it is — the latest daydream of Washington's dreamin' Dreamboats — parked in the collective laps of all American physicians, gift-wrapped, labeled, and delivered in person by the Right Honorable Mr. Folsom, Secretary of HEW, and Member of the President's Cabinet.

Speaking from the rostrum of the 1956 Annual Meeting of Blue Cross and Blue Shield Plans, Mr. Folsom stressed his Department's deep concern over the health and welfare of the aged and infirm-aged citizens of this nation. He also indicated that this growing problem had been placed near the top of the 1957 agenda. Furthermore, he left the impression that, quite by chance, this new and unique innovation had been brewing for sometime in the electronic cauldron for which HEW and its predecessor have long been famous.

"Purchase and pay for in full while you are young, the health-care protection you *will be sure to need* when you are beyond your productive years." This was the essence of Mr. Folsom's thesis. He then advised extensive creative research for the development of a *practical Paid-up* Voluntary Health Insurance Plan. He presented it as a challenge, and bore down on *urgency*. Finally, he hinted at, but made no commitments regarding a fiscal boost from the federal government.

Now, here is an idea which will no doubt keep the lights of many an electronic brain doing flip-flops from now until next St. Swithen's Day and then some. The *paid-up* concept may look like gold to the centenarian classes, but to the safe-and-sane characters in the actuarial fraternity, it has the apearance of Nothing — dressed up in a couple of counterfeit greenbacks.

Why? Because it violates three of the six basic principles of insurance underwriting. First: once born, mortal man inevitably grows older day by day, until after a total of 21,925 days, he is no longer considered either young, or employable. And — by the same token, he is virtually a sure-fire candidate for paid-up benefits. Thus, there is not now, nor will there ever be room for the essential "uncertainity of occurrence" in the proposed paid-up philosophy.

Second: the average citizen of thirty, perceiving the subsequent downhill course of life's pathway, would be a lead-head if he did not take out some paid-up health insurance with which to comfort his arteriosclerosis homens later on when winter feels like winter, even during the summer. Ergo: the paid-up idealogy *does* immeasurably increase the risk. The subscriber has purchased definite paid-up benefits, and he will inevitably try to get what he believes he has coming to him.

Third: There are no *large* numbers of *independent* risks. A centenarian is a centenarian no matter where you find him, and they are, one and all, firmly consolidated behind the banner of Old-Man Time.

Admittedly, when first introduced, the paid-

up day-dream seems as irrational and unsound as anything yet encountered during these Herculean decades. However, after kicking it up and down "Actuarial Row" a couple of dozen times, you will be amazed to discover that it still seems irrational and unsound.

Yet, no one can deny that it *is* a "forward step," that it *will* stimulate exploration of the unknown, and that it *does* suggest the existence of a modern happy hunting ground just beyond the nearest horizon — not for the dead, but for the "quick," and the aged, and the elderly ill.

So, the cauldron boils, the dreamboats dream, and the wheels of fortune spin. Meanwhile this ancient practitioner continues to wonder whether Mr. Folsom seriously anticipates another miraculous production by Blue Cross and Blue Shield, or whether he is merely setting the stage for further expansion of the Federal Social Security Act. Either way, it might be a good idea to remove the ground-glass lenses from your telescope and take a good long look at the "paid-up principle" as applied to voluntary health insurance.

Maybe after all, the Blue Plans can make this impossible dream become impossible reality as they have so many times in the past. Who can claim, in all honesty, that they will not do it . . . once again. But — if they should fail, or falter, then by one means or another we shall probably be invited to join Uncle Sam in singing a new version of an old favorite. Let's call it, "Golden Threads among the Silver."

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Worcestershire sauce not a beverage

A remarkable example of prognostic failure was occasioned by a business man, highly successful in his financial dealings, aged 59, limited in activity by virtue of visual defect, happily married, and living in comfort. He developed headaches, drowsiness, thirst, occasional loose stools, nausea, and loss of weight. His doctor found that the urine was of fixed low specific gravity (1004); it was loaded with albumin and contained some granular casts. The blood urea was 76 mg. per 100 ml., rising in a month to 100 mg. The blood pressure had risen from his normal 150/80 to 190/106. The urea clearance test revealed 18 per cent of normal function. He concluded that his patient had chronic nephritis, a view that was endorsed by the consultant to whom he brought the case. In the course of the next three months the symptoms became worse. Albumin was found in considerable quantity in nearly all specimens of urine. A bad prognosis was given; it was thought that the patient would die within the next three months. He was instructed in the traditional lines of dieting for chronic nephritis, and he followed these with care. After a week or two he asked his doctor if the consumption of Worcestershire sauce was in any way harmful. It seemed that he had been taking from one-half to one bottle of it for many years. He said he did so because he liked it. Whatever the reason for his consumption of this enormous quantity, the fact remains that he did take it as a beverage. It was promptly stopped. Within a month the albumin and casts disappeared, the blood pressure and blood urea had returned to normal, the patient rapidly put on weight. Two years afterward he is symptomless, and the only sign of latent renal disease is occasional albuminuria. This is, I think, an error in prognosis which might be forgiven. *A. H. Douthwaite. M.D. Pitfalls in Medicine. Brit. M.J. Oct. 27,* 1956.

THE P. R. PAGE



Edward A. Uzemack, Director of Public Relations

BILLS are flowing into the hopper in the State Legislature at a rapid pace. Many of these deal with medical service, some in a major way.

The Illinois State Medical Society's Committee on Medical Service and Public Relations will analyze these bills for their possible effect on the quality of medical care, and report accordingly. Recommendations will be made in some instances.

County medical societies already have been alerted to be ready for concerted action when united support of or opposition to any measure is necessary. Notices will be sent to county societies immediately when occasions arise. When advised to act, doctors should do so at once.

Meanwhile, physicians should know something about the important measures pending as this issue went to press. Some are good from the standpoint of the public's health and welfare; others bad.

Two Senate Bills—59 and 63—fall in the first category and in present forms are worthy of the wholehearted support of physicians.

Senate Bill No. 59 provides for a single amendment to the Medical Service Plan Act of 1945, passed at the request of the Illinois State Medical Society. This is the enabling act for Blue Shield.

The proposed amendment is to be found in Section 2, subsection 3, which covers definitions. The amedment would change the subsection to read:

(3) "Medical Service" means the ordinary and usual professional services rendered by physicians licensed in Illinois to practice medicine in all of its branches, *as well as like services when lawfully rendered in a licensed hospital by persons licensed in this state under the Dental Practice Act,* and shall not mean hospital services.

The words in italics are an addition to the existing Act. By its terms, certain types of services rendered by a dentist in a licensed hospital would be included under Blue Shield payments.

The Illinois State Medical Society's Committee on Medical Service and Public Relations is supporting the Bill in its present form. The Society opposed an amendment presented two years ago because the changes then proposed would have adversely affected the financial stability and growth of medical service plans now in operation.

Senate Bill No. 63 (Coroners' Bill) was introduced at the request of the Illinois Coroners' Association and the Illinois State Medical Society. It also has the tentative approval of the newly formed Board on Necropsy Service of the Illinois Department of Health.

Briefly, the Bill:

(1) Defines what types of deaths constituted coroners' cases;

(2) Requires the impaneling of a coroners' jury only in cases of suicidal, homicidal or accidental death, thereby saving money for counties;

(3) Provides for an improved quality of post-mortem examinations in many areas by making capable autopsy surgeons more readily available throughout downstate (to be done in conjunction with the Board on Necropsy Service to Coroners).

(4) Requires the approval of the coroner before cremation can be undertaken.

It is the opinion of the Illinois State Medical Society's Committee on Medical Service and Public Relations that this Bill would improve the administration of justice where a coroner's investigation is involved by strengthening the medical examination of the cause of death.

The Bill is not intended to interfere with the administration of the Coroner's office, or the legal investigation of the causes of death. On the contrary, by creating a regional system of improved pathological service to coroners, it is hoped that a better quality of medical investigations will result.

Members of the Illinois State Senate have been asked by the Illinois State Medical Society to support the Bill. Physicians should strengthen this with individual requests to their respective Senators.

Also presented was a completely new "Workmen's Compensation and Rehabilitation Act." This was drawn up by the Illinois State Medical Society's Committee on Industrial Health.

A detailed account of that important measure was carried in the January issue of The Illinois Medical Journal, pages 40-43. It is hoped that all interested groups as well as individual physicians will do their utmost in facilitating passage of the Bill.

Senate Joint Resolution No. 8 also has been introduced. This would create a joint legislative commission to study statutes relating to healing, curing or relieving of illness, injury or disease of body or mind. The commission is to report its findings to the Legislature by May 1.

Developments in this Bill will bear watching because of possible far-reaching effects.

Medicine has to be ever on the alert. Unless a watchful eye is kept on legislative matters in Springfield, Bills inimicable to the public and the profession will slip through.

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World Congress of gastroenterology

The World Congress of Gastroenterology is being sponsored by the International Society of Gastroenterology and the host organization in this country is the American Gastroenterological Association. The meeting is to be held in Washington, D.C., May 25-31, 1958 at the Sheraton Park Hotel. All physicians interested in gastroenterology are cordially invited to attend. The Chairman is Dr. Harry L. Bockus and anyone desiring information regarding the program, housing, etc. may direct all correspondence to me.

The major subjects to be considered at the scientific session are as follows: Peptic ulcer, malabsorption and sprue-like syndromes, nutrition and its effect on the liver and pancreas, intestinal infection and infestation, and cancer of the stomach.

H. M. Pollard, M. D.,
Secretary General,
University Hospital,
Ann Arbor, Michigan.

CORRESPONDENCE



Woman's auxiliary call to meeting

The Month is May
The Dates are 21-24
The Place is Chicago

Not only for the Annual Meeting of the Illinois State Medical Society, but for the Convention of its Auxiliary, a cordial invitation is extended to all doctors' wives.

The Sherman Hotel is headquarters for both the Society and the Auxiliary. The attractions of Chicago and the hospitality of our members there are well known to you, but I would like you to know some of the attractions of the 1957 program.

Among the social events which provide an atmosphere for extending friendships and making new ones, are two luncheons. The Champaign Auxiliary will hostess the Wednesday luncheon; Tazewell County Auxiliary, the Thursday luncheon.

Tuesday evening promises to be a special combination of fact and fiction - to be enjoyed by members of the Society, the Auxiliary and guests. All of you are invited to the Public Relations Dinner of the Illinois State Medical Society, which will feature Mr. Paul Jones of the National Safety Council. Following the dinner, everyone will proceed to a gala cabaret party with dancing and entertainment for the remainder of the evening. You will be the guests of the Medical Society for the post dinner festivities, the Auxiliary being your hostess.

We take great pride in honoring Mrs. G. Henry Mundt, Founder and First President of the Illinois Auxiliary, and Mrs. James P. Simonds, National Honorary Emeritus Publications Chairman. The Convention honors them with a continental breakfast on Wednesday morning.

Another distinct part of the Annual Meeting, not social, yet interesting and informative, are the two sessions devoted to reporting local projects and activities, evaluating what has been accomplished and introducing new ideas. This deliberation is the pattern for future growth and a prerequisite for leadership.

Time has been allotted for disposition of essential business. These matters deserve the consideration of all of our members.

A Twilight Memorial Service will follow the Tuesday afternoon delegate session.

The complete program for the 1957 Convention will appear in the next issue of the Illinois Medical Journal.

I have met so many wonderful wives of doctors in past years and have enjoyed each and every one of you. It will be nice to greet you again and to make new friends. Old friends were once new friends. Do come!

Sincerely,
(Mrs. S. M.) Myrtle Hubbard
Convention Chairman

The Month is May
The Plans are made
The Convention is You

Dr. Nicholas Nyaradi is auxiliary luncheon speaker

Dr. Nicholas Nyaradi, former Minister of Finance of Hungary and now an American citizen, is Chairman of the Economics Department of Bradley University, Peoria.

Dr. and Mrs. Nyaradi fled Hungary and came to America when his position became untenable because of the encroachment of Russian sponsored communism in his native country.

As one of the leaders of the democratic Small Farmers Party in post World War II Hungary, he served his government for four years, first as Under Secretary of the Treasury, then as Minister of Finance. He was sent to Moscow to negotiate settlement of a Soviet claim against the Hungarian government, an assignment which lasted seven months. During that time Dr. Nyaradi was frequently in contact with many high ranking officers of the Politburo and also knew members of the Secret Police. These experiences are the background for his interpretation of plans, goals and methods of Soviet imperialism and infiltration.

Since coming to this country, Dr. Nyaradi has lectured widely; his messages have been heard over radio and television. He received a citation for his work on behalf of the Crusade for Freedom and Radio Free Europe from Henry Ford II as Chairman of the American Heritage Foundation.

Dr. Nyaradi has published articles in the Saturday Evening Post, Fortune, The Reporter, United Nations World and the Chicago *Tribune*. His book, "My Ringside Seat in Moscow" has been considered an outstanding antisubversive publication.

His vital messages are given in clear, intelligible, almost classical English. The Auxiliary is pleased to have Dr. Nyaradi as guest speaker at its luncheon on Wednesday, May 22.

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State-wide scientific program on diseases of the heart

A discussion of pathogensis and current trends in therapy for hypertension, rheumatic fever, coronary heart disease, congestive heart failure, and heart disease amenable to surgery will be presented jointly by The Chicago Heart and the Illinois Heart Associations on Friday, March 22, 1957.

The program starts at 2:00 p.m. and the dinner at 6:30 p.m. For dinner reservations call or write the Chicago Heart Association, 69 W. Washington St., Chicago or phone FInancial 6-4675, or the Illinois Heart Association, 715 S. Sixth St., Springfield, or phone 8-4361.

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Clinics for crippled children listed for April

Twenty four clinics for Illinois' physically handicapped children have been scheduled for April by the University of Illinois, Division of Services for Crippled Children. The Division will count 17 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing service. There will be 3 special clinics for children with cardiac conditions, 2 for children with rheumatic fever, and 2 for cerebral palsied children.

Clinics are held by the Division in co-operation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

The April clinics are:

April 2 - Quincy, Blessing Hospital

April 3 - Alton (Rheumatic Fever), Memorial Hospital

April 3 - Hinsdale, Hinsdale Sanitarium

April 4 - Flora, Clay County Hospital

April 9 - East St. Louis, Christian Welfare Hospital

April 9 - Peoria, Children's Hospital (St. Francis)

April 11 - Cairo, Public Health Building

April 11 - Springfield, St. John's Hospital

April 11 - Watseka, American Legion Hall

April 12 - Chicago Heights (Cardiac), St. James Hospital

April 16 - Danville, Lake View Hospital

April 17 - Chicago Heights General, St. James Hospital

April 17 - Elmhurst (Cardiac), Memorial Hospital of DuPage Co.

April 18 - Rockford, Rockford Memorial Hospital

April 19 - Evanston, St. Francis Hospital

April 23 - Belleville, St. Elizabeth's Hospital

April 23 - Peoria, Children's Hospital (St. Francis)

April 24 - Elgin, Sherman Hospital

April 24 - Springfield (Cerebral Palsy), Memorial Hospital

April 25 - Bloomington a.m. (General), St. Joseph's Hospital p.m. (Cerebral Palsy)

April 25 - Mt. Vernon, Masonic Temple

April 26 - Chicago Heights (Cardiac), St. James Hospital

April 30 - Effingham (Rheumatic Fever), St. Anthony Hospital

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Refresher courses

The following short refresher courses will be given at The Children's Hospital of Philadelphia in May and June 1957.

1. PEDIATRIC ADVANCES FOR PEDIATRICIANS AND GENERAL PRACTITIONERS. May 27 through May 31, 1957. Conducted by the Staff of the Children's Hospital of Philadelphia, in collaboration with the Department of Pediatrics of the University of Pennsylvania and the Staff of the Camden Municipal Hospital. Tuition—$110.00

2. PRACTICAL PEDIATRIC HEMATOLOGY. June 3, 4 and 5. Conducted by Irving J. Wolman, M.D. and other members of the Hematology Department of the Children's Hospital, under the auspices of the Graduate School of Medicine, University of Pennsylvania. Tuition—$75.00

3. BLOOD GROUP INCOMPATIBILITIES AND ERYTHROBLASTOSIS FETALIS. June 6 and 7. Conducted by Neva Abelson, M.D. and Thomas R. Boggs, Jr., M.D. of the Philadelphia Serum Exchange of the Children's Hospital of Philadelphia, under the auspices of the Graduate School of Medicine, University of Pennsylvania. Tuition—$50.00

Inquiries should be addressed to Irving J. Wolman, M.D., Children's Hospital of Philadelphia, 1740 Bainbridge Street, Philadelphia 46, Pa.

Tentative program for Secretaries' Conference

Leland Hotel, Springfield, March 24

Chairman: Dr. Norris J. Heckel ..... Chicago

Vice-Chairman: Dr. E. Newton Du Puy .... Quincy

Local Chairman: Dr. Jacob E. Reisch ..... Springfield

Secretary: Dr. George C. Turner ..... Chicago

9:00-9:25	Registration
9:30-9:40	Opening of the Meeting and Welcome . . . . Dr. Lester S. Reavley, Sterling, President-Elect, Illinois State Medical Society.
9:40-10:10	"Automobile Safety: A Problem" . . . Mr. Charles A. Carpentier, Springfield, Secretary of State.
10:10-10:40	"The Medicare Program and the Hospitalization of Veterans with Non-Service Connected Disabilities", from the American Medical Association's Standpoint . . . Dr. Edwin S. Hamilton, Kankakee, Trustee of The American Medical Association. "Medicare" — From the point of view of the Fiscal Administrator . . . Dr. Frederick W. Slobe, Chicago, Medical Director, Blue Cross Plan
10:40-11:00	Coffee
11:00-11:40	"Civil Defense" . . . Dr. Charles L. Maxwell, Chicago, Deputy Director of Health, Illinois Department of Civil Defense. "What the Secretary Should Know About Civil Defense" Dr. Earl H. Blair, Chicago, Chairman — Civil Defense Committee, Illinois State Medical Society
11:40-12:00	"Pending Legislation" — Mr. Walter L. Oblinger, Springfield, Associate Counsel, Illinois State Medical Society

12:00-12:20 Social Hour

12:20-1:50 Luncheon Address . . . "Medicine: A Look at the Past and to the Future" Dr. Austin Smith, Chicago, Editor, Journal of American Medical Association

Those attending the Conference, and their wives will be guests of the Illinois State Medical Society for luncheon.

2:00-4:00 Panel Discussion

Moderator: Dr. Harold M. Camp, Monmouth, Secretary, Illinois State Medical Society.

1. Indoctrination of New Members . . . Dr. James Rutledge, Pittsfield
2. Planning Programs to Interest the Apathic Member — Dr. Fred A. Tworoger, Chicago
3. Pepping Up the County Society Bulletin . . Dr. Hilliard Shair, Quincy
4. Society Committee Activities — Dr. Joseph T. O'Neill, Ottawa
5. Public Relations . . . Dr. H. Kenneth Scatliff, Chicago
6. What the Secretary Can Do to Increase Attendance at the State Medical Society Meetings — Dr. Jacob E. Reisch, Springfield
7. What's Your Question?

4:00 Election of Officers Secretaries Conference

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National Industrial Health Conference

The Twelfth National Industrial Health Conference will be held at Kiel Auditorium, St. Louis, Missouri, April 20-26, 1957.

Some 200 of the country's leading specialists and experts in the complexities and technicalities of preventive medicine and hygiene in industry will present the latest findings and developments in this field.

The formal sessions — more than 40 in number — include symposiums and panel discussions on subjects of timely interest; special meetings of the various groups; and conferences of special committees. In addition, there will be meetings of company physicians — steel, oil, electric, auto — starting with the all-day conference of General Motors physicians on Monday, April 22.

The conference provides an unexcelled opportunity for postgraduate study of new ways to improve and preserve the health of the American worker. The complete program may be obtained by writing E. C. Holmblad, M.D., Managing Director, Industrial Medical Association, 28 East Jackson Boulevard, Chicago 4, Ill.

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American Congress of Physical Medicine and Rehabilitation

The next meeting of the Midwestern Section of the American Congress of Physical Medicine and Rehabilitation will be held in Rochester, Minnesota at the Mayo Clinic, on May 3 and 4. There will be a Scientific Session as well as tours of the various facilities in the Mayo Clinic.

Those interested in attending are urged to write to Dr. Gordon M. Martin, Section of Physical Medicine and Rehabilitation, Mayo Clinic, Rochester, Minnesota. Please let him know if you will need hotel or motel reservation.

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The Illinois Society of Anesthesiologists

Knickerbocker Hotel, Chicago
Saturday, March 23, 1957

5:30 p.m.—Social Gathering, Foyer, Roof Garden Floor

6:30 p.m.—Dinner, Oceanic Room

8:00 p.m.—Scientific Program, Towne Room

Panel Symposium on "The Anesthesiology Resident Program."

Moderator: *William O. McQuiston, M.D.,* Attending Anesthesiologist, Childrens Memorial Hospital, Chicago; and Consulting Anesthesiologist, St. Francis Hospital, Peoria.

Panel Members: *Ralph M. Tovell, M.D.* Chairman, Department of Anesthesiology, Hartford Hospital, Hartford, Conn.; Consultant to the Central Office, Veterans Administration, Washington, D. C.; and to the Office of the Secretary of Defense.

Ivan B. Taylor, M.D., Professor of Clinical

Anesthesiology, Wayne State University, College of Medicine and Attending Anesthesiologist, Harper Hospital, Detroit, Michigan.

Lawrence D. Ruttle, M.D., Attending Anesthesiologist, St. Joseph's Hospital and Silver Cross Hospital, Joliet, Ill.

Clifford A. Baldwin Jr., M.D., Chairman, Department of Anesthesiology, Evanston Hospital and Associate in Surgery (Anesthesiology), Northwestern University Medical School, Chicago.

Audience participation in question and answer period to follow.

Physicians are cordially invited to attend. (Dinner reservations must be made before March 15 with H. Livingstone, M.D., 5805 Dorchester Avenue, Chicago).

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Bahamas Medical Conference

At the last monthly meeting of the Bahamas Branch of the British Medical Association in Nassau on January 3rd, the holding of another Bahamas Medical Conference during the week after Easter, April 23rd to 30th, 1957, was approved.

This next Conference will be held at the British Colonial Hotel and the Princess Margaret Hospital in Nassau. On weekdays, lectures will be given from 9.30 to 11.00 a.m. and 5.30 to 7.00 p.m. There also will be two evening lectures, two meetings at the hospital, and two evening social gatherings. I shall be happy to send you the full program in due course, if you will kindly write to me.

The British Colonial Hotel has offered special rates for the participants of this Conference and their wives:

Modified American Plan: Two persons in one room, $30.00 for room, breakfast and dinner, per day, for two; One person in one room, $20.00 for room, breakfast and dinner, per day, for one.

Hotel reservations should be made as early as possible by writing (airmail ten cents postage from the United States or Canada) *directly* to Mr. Robert K. Holiday, Reservations Manager, British Colonial Hotel, Nassau, Bahamas, and by sending at the same time the registration fee of $75.00.

The usual official certificate of attendance for U.S. income tax purposes will be issued to the participants in the Conference.

There will be ample time for recreational activities. The average temperature in Nassau in April is around 70 degrees. There are no tropical illnesses on the island. Inoculations are not required. Americans do not need passports but only evidence of citizenship. There are direct non-stop flights to Nassau from New York and from Miami on Pan American Airways and on British Overseas Airways. From Canada there are direct flights on Trans-Canada Airlines.

It is hoped that a large number of doctors and their families will be able to enjoy a short vacation combined with an interesting medical program.

Dr. B. L. Frank, Organizing Physician

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Venereal disease P.G. conference

The 26th Venereal Disease Postgraduate Conference for physicians sponsored by the University of Tennessee College of Medicine, the Public Health Service, and the Tennessee State Department of Health will be held at the College of Medicine in Memphis, April 18-20, 1957 inclusive. The course is designed to acquaint the practitioner and health officer with the latest developments in the diagnosis, treatment, and management of venereal diseases. No tuition will be charged. Members of the American Academy of General Practice will be granted 20 units of Category I credit toward the postgraduate educational requirements of the A.C.G.P. for full attendance at this course. Applications for admission are to be sent to Dr. Henry Packer, Department of Preventive Medicine, College of Medicine, University of Tennessee, Memphis 3, Tennessee.

The instructional staff for the course will be drawn from university facilities, Public Health Service personnel, and other outstanding authorities in the field.

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AT THE EDITOR'S DESK

A NEW series of research microscopes with push-button illumination for faster and easier specimen analysis was announced recently by Bausch & Lomb Optical Company. The new illumination system is an achromatic variable focus condenser, which contains unusually large lenses. Other important developments are eyepieces fitted with rubber inserts to protect the user's glasses; a control location that enables the operator to make adjustments without raising his hand from the table; concentric coarse and fine focusing knobs for the substage; and a graduated pupillary distance scale on the binocular eyepiece.

The Chemstrand Corporation announced recently that their new, nylon, Y-shaped artery to replace the aorta at the bifurcation has been used successfully on more than 200 patients. This nylon graft was used to replace localized obstructions in the aorta and is said to compete favorably with human arterial grafts. The problem with many previously man made replacement arteries was their tendency to kink with body movements, thus interfering with the flow of blood. The Chemstrand graft is a crimped, braided, nylon tube that bends 180 degrees without kinking.

The winter edition of Your Radiologist carried the following paragraph: "The doldrums, a virus sometimes contacted by doctors at scientific meetings from hearing too many long-winded speakers read medical articles, may be prevented or cured by using a prescription offered by Dr. Robert P. Barden of Philadelphia. 'Finish the paper before the time allotted to it' is the first ingredient of the prescription. 'Never say all you know and retire from the podium while your listeners are hoping for more,' the prescription adds. As with many prescriptions, this one probably will be ignored by those who need it most, say some of the virus sufferers."

The question and answer department of the British Medical Journal came up with an odd industrial hazard. The question: A man was offered a job in a laboratory that prepared ovarian extracts. Apparently, during the process of grinding the dried ovaries, the atmosphere becomes laden with ovarian dust. Is this dust likely to affect his health? The physician who answered the query found the situation unique. He doubted that the estrogen content of the dust was great enough to have a specific effect. On the other hand, he believes there is a possibility of an allergic reaction and suggested that the dust be controlled through proper ventilating equipment.

The population of the United States increased 29½ million since World War II. Every geographical area shared in this growth but the far west showed the highest rate of increase. California gained 3.1 million inhabitants; its total population is 13.7 million, which is exceeded only by New York State. Nevada, Arizona, and Florida also experienced rapid population growths.

Pfizer combined Atarax with prednisolone and found it enabled 12 out of 21 arthritics to reduce their maintenance dose of the steroid.

A group of Dutch investigators at the University of Leyden confirmed the efficacy of Furadantin in the management of urinary tract infections. According to a news release, the investigators produced sterile urine in 76 per cent of 89 patients with urinary tract infection. The compound was effective in about 70 per cent of 28 patients who had not responded previously to antibiotics or the sulfonamides. "The drug was of special usefulness in general practice," according to the release, "because its consistently wide antibacterial spectrum did away with the need for routine bacterial sensitivity tests."

Forty quarts of Albumisol, rushed by the Civil Air Patrol to New Haven, Conn., where a disastrous fire occurred, were credited with saving many lives. This blood volume restoring agent is a 5 per cent concentration of normal serum albumin. According to Merck Sharp & Dohme, the product increases blood volume and will carry cases of shock through the first 12 hours if necessary.

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The legal abortion

The Praesidium of the Supreme Soviet, in its session of Nov. 23, 1955, passed a decree entitled "The Repeal of the Prohibition of Abortions." In the commentary preceding the text it noted that the measures enacted by the Soviet state to encourage motherhood and protect infancy, as well as the uninterrupted growth of the consciousness and culture of women who participate in all areas of economic, cultural, and social life, permits "at the present time the lifting of the prohibition on abortions in the legal sense; the prevention of abortions may be secured through a further broadening of state measures to encourage motherhood and measures of an educational and explanatory nature." The decree then hints at the real reason for the change: "The repeal of the prohibition on abortions will permit the limitation of the harm caused to the health of women by abortions carried out outside hospitals." Thus, the Praesidium of the Supreme Soviet, "in order to give women the possibility of deciding by themselves the question of motherhood. . . .has decided to repeal the previous law on abortions." *Mark G. Field. The Re-Legalization of Abortion in Soviet Russia. New England J. Med. Aug.* 30, 1956.

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Are you covered?

It was recently brought out in testimony before a Congressional subcommittee of the Senate Committee on Labor, that 12,500,000 workers were covered by private pension systems; 28,762,000 workers were covered by group life insurance plans; and there were 62,241,000 workers or dependents under hospitalization plans at the end of 1954. At the same time there were 800,000 retired workers drawing benefits from private firms and, with their wives, this total was 1,200,000 persons. *Beverly C. Smith, M.D. Indigency Among Doctors. New York J. Med. Oct.* 1, 1956.

NEWS of the STATE



ADAMS

Staff Election.—Newly elected officers of St. Mary's Hospital staff include Dr. Aldo German, president; Dr. Kent Barber, vice-president; and Leroy M. Wolfe, D.D.S., sceretary-treasurer.

New Physicians.—Dr. K. George Tietz started to practice pediatrics in the Broadway Bank Building, Quincy, January 1. He graduated in Germany, coming to the United States in 1951. His training since that time has been at Municipal Hospital in Tampa, Florida, and the Tampa County Hospital. He also has served a rotating internship at the Rockford Memorial Hospital in Rockford and a two-year residency in pediatrics at the Research and Educational Hospitals, Chicago.

Dr. Manfred Kydan has joined the staff of the new Mental Health Clinic as medical director. Dr. Kydan, who also graduated in Germany, came to the United States in 1939 and became a citizen in 1945. He served his internship at St. Mary's Hospital in Quincy and general residencies at the Moline Public Hospital and the Highland Baptist Hospital, Birmingham, Ala. He has also served at the East Gardner State Hospital in Gardner, Mass., and at the East Moline State Hospital in Illinois.

COOK

University News.—Dr. John A. D. Cooper, assistant dean at Northwestern University Medical School, has been appointed to serve on the Atomic Energy Commission advisory committee on isotope distribution.—Dr. Milton Miller has been appointed clinical assistant in medicine at Chicago Medical School.

The Herrick Lecture.—Dr. C. Walton Lillehei, professor of surgery, University of Minnesota Medical School, Minneapolis, presented the second James B. Herrick Memorial Lecture, February 12, under auspices of the Chicago Heart Association. The title of his lecture was "Recent Advances in Heart Surgery By Use Of Open Cardiotomy."

Lectures on History of Surgery.—In a series of lectures on the history of surgery, the International College of Surgeons recently presented the following: Dr. Guy Kasten Tallmadge, professor of history of medicine, Marquette University School of Medicine, "Early French Surgery;" Eugene M. K. Geiling, Frank B. Hixon Distinguished Service Professor Emeritus, department of pharmacology, University of Chicago, "Antisepsis and Asepsis", and Lloyd G. Stevenson, professor of the history of medicine, McGill University Faculty of Medicine, Montreal, "British Anatomists and Surgeons."

Ninety-One Years Young.—Dr. Vida A. Latham observed her ninety-first birthday, February 4. Dr. Latham, who was born in Lancashire, England, graduated at Northwestern University Medical School. She has been practicing sixty-eight years. The Loop Zonta gave a dinner in her honor to celebrate her birthday. She is said to have many hobbies, being an accomplished organist and piano player. Her current hobby, according to the Chicago Tribune, is film cutting.

Scholarship Named for Dr. Stack.—A full-tuition, four-year scholarship has been established at Northwestern University Medical School in honor of Dr. James K. Stack, associate professor of orthopedic surgery at the school. Established by Dr. and Mrs. John William Howser, Oak Park, the scholarship is to be awarded to an incoming freshman medical student selected by the school's scholarship committee. At the end of each four years, a new student will be selected. Dr. Howser graduated at Northwestern in 1937.

Resident Fellowship in Dermatology.—The Toni division of the Gillette Company, Chicago, has established a resident fellowship at Northwestern

University Medical School which will be known as the Gillette-Toni fellowship in dermatology. The fellowship carries an award of $2,000 a year for an unmarried student and $2,500 for a married student. An additional fund of $1,500 will be provided for the expense of training the resident. The first recipient will be named sometime next year by Dr. Herbert Rattner, chairman of the department.

Faculty Appointments.—The Chicago Medical School announced the following appointments to its faculty: Drs. Morris Binder, clinical assistant in medicine; William R. Clarke, assistant in medicine; Nathan A. Cohen, assistant in pathology; Donald R. Frankel, clinical instructor in medicine; Ben Gelfand, clinical assistant in gynecology and obstetrics; Harold D. Omens, clinical instructor in dermatology, and Rochus Stiller, instructor in psychiatry.

New Obstetrical Department.—The opening of a new obstetrical department at Louis A. Weiss Memorial Hospital was to have taken place on March 15. The new addition, constructed at a cost of $350,000, will house two labor rooms each containing two beds, a formula room and two delivery rooms, the addition will have facilities for twenty-one beds, and some twenty-one to twenty-five bassinets.

Dr. van Elk Heads new Cardiovascular Laboratory.—Dr. Jack van Elk has been named chief of the newly equipped cardiovascular laboratory for the study of congenital and acquired heart disease at Mercy Hospital. The laboratory is administered by the Stritch School of Medicine of Loyola University. Dr. van Elk, who studied medicine at the University of Utrecht, became interested in cardiology while preparing for medical admission examinations in New York. At the University of Colorado School of Medicine, where he was located prior to coming to Chicago, Dr. van Elk was in charge of the institution's cardiovascular laboratory.

New Officers of Institute of Medicine.—Dr. Eric Oldberg was elected president of the Institute of Medicine of Chicago at a recent annual meeting. Other officers chosen were: Drs. H. P. Saunders, vice-president; George H. Coleman, secretary; E. Lee Strohl, treasurer, and Henry T. Ricketts, chairman of the Board of Governors. Drs. Warren H. Cole, Ernest G. McEwen and Walter H. Theobald were elected to serve as members of the Board of Governors for terms of five years each.

Personal.—Dr. Francis J. Haddy of the U. S. Army Medical corps at Fort Knox, Kentucky, has been appointed to a full time research position at the North Side Veterans Administration Research hospital, newspapers reported January 23. Dr. Haddy is one of nine clinical investigators named by the VA in a new program intended to produce more and better research on medical problems. Each of the new clinical investigators will spend at least three-fourths of his time in research, under an outstanding representative in his special field. The fields include neurology and psychiatry, heart and blood vessels, cancer, degenerative diseases, and problems of aging.—Dr. John Mart, associate professor of medicine, Northwestern University Medical School, addressed the Fort Myers Beach (Fla.,) Rotary Club recently on "Common Misconceptions Regarding the Heart and the Attack."

Hospital News.—Dr. Charles F. Hubner, Brookfield, was elected president of the medical staff at MacNeal Memorial Hospital, Berwyn, recently. Dr. Victor P. Slepikas, Brookfield, was elected vice-president and Dr. R. Mrazek, Riverside, secretary. MacNeal Hospital has just completed its 25th year of operation as a non-profit institution managed by the Berwyn Hospital Association. Francis J. McCarthy, administrator of MacNeal, hailed the hospital's growth in a recent report to the Board of Directors. In 1956, he said, the hospital reached an all-time high in the number of patients admitted, number of births and the number of patient days spent in the hospital.—Dr. Leonard M. Wagner, Niles, was recently elected president of the medical staff of Alexian Brothers Hospital where he is attending physician in the department of urology. Dr. W. W. Patrick, Chicago, was named vice-president and Dr. Cornelius Colangelo, secretary-treasurer.

Course on Neuromuscular Diseases of Children.—The Cook County Graduate School of Medicine will conduct an intensive course in neuromuscular diseases of children with special emphasis on cerebral palsy, July 8-19, under the direction of Dr. Meyer A. Perlstein. The course is designed for pediatricians, orthopedists, neurologists, psychiatrists and physiatrists interested in the care and treatment of children with neuromuscular handicaps. Emphasis will be placed on the practical clinical aspects of treatment and rehabilitation procedures. The course will include itinerant clinics to round out the program in most of its practical aspects. The fee for the course, which is $250, will include the cost of luncheons during the two-week period, as well as the expense of travel, meals and accommodations during the trip to the field clinic. For further information, write to John W. Neal, Registrar, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Ill.

Cardiovascular Diagnostic Methods.—The Chicago Heart Association will present a symposium on cardiovascular diagnostic methods in the Walton Room of the Drake Hotel, April 23, with Dr. Aldo Luisada, director of the division of cardiology, Chicago Medical School, acting as moderator. Participants will be Drs. John Nickerson, professor and chairman, department of pharmacology at the school, on "Ballistocardiography"; Klara Prec, assistant professor of medicine, University of Chicago School of Medicine, on "Dye Dilution Techniques"; A. A. Luisada, director and C. K. Liu, research associate division of cardiology department of medicine, Chicago Medical School, on "Electro-

kymography of the Left Atrial Pressure Patterns", and John F. Perkins, associate professor of physiology, University of Chicago School of Medicine, on "Rapid Evaluation of Pulmonary Function". Discussants will be Drs. Richard Jones, assistant professor of medicine, University of Chicago School of Medicine; Harry Bliss, assistant professor of medicine, University of Chicago School of Medicine; Paul Kezdi, director, Heart Station, Wesley Memorial Hospital, and William Barclay, associate professor of medicine, University of Chicago School of Medicine.

Eugene Geiling Retires.—Dr. Eugene M. K. Geiling has retired as chairman of the department of pharmacology of the University of Chicago School of Medicine. Aged 65, Dr. Geiling, has been a Frank P. Hixon Distinguished Service Professor since 1941 and professor and chairman of pharmacology since 1936.

Dr. Lloyd J. Roth, who has been a member of the department of pharmacology since 1952, will succeed Dr. Geiling. He is best known for his work on synthesis of radioactive drugs and their action.

Dr. Geiling, who retired with the rank of professor emeritus, will follow his long-cherished ambition of writing the biography of his famed teacher, Dr. John Jacob Abel, often called the father of modern experimental pharmacology in the United States. According to a news release from the University of Chicago, Dr. Geiling was part of the group who, under Dr. Abel at Johns Hopkins University Medical School, crystallized insulin in 1925 and paved the way for fundamental studies and a crystalline standard of the drug.

Like Dr. Geiling, Dr. Roth holds both a Ph.D. and an M.D. The former he received at Columbia University and the latter at the University of Chicago.

The Growth of Medicine.—The third annual series of lectures on the growth of medicine sponsored by Northwestern University Medical School, opened January 8 with a talk by Barry J. Anson, Ph.D., professor of anatomy at the medical school, on "The Debt of Medicine to Ancient Greece and Rome." Others in the series are: Frederick Stenn, M.D., associate professor of medicine at the school, on "The Symbol of Medicine"; Raymond W. McNealy, M.D., associate professor of surgery emeritus at the school, on "The Influence of the Cook County Hospital on Medical Education in the United States"; Benjamin Boshes, M.D., professor of neurology and psychiatry at the school, on "The Development of Our Knowledge of Psychiatry"; Elza Veith, Ph.D., assistant professor of the history of medicine, University of Chicago School of Medicine, on "Medical Ethics Through the Ages"; Lester Dragstedt, M.D., chairman of the department of surgery at the school, on "Siamese Twins"; William B. Wartman, M.D., professor of pathology at Northwestern on "The Growth of Our Knowledge of Tumors"; Samuel J. Zakon, M.D., associate professor of dermatology at the school, on "Religio Medici"; Leslie B. Arey, Ph.D., professor of anatomy emeritus at the school, on "Medicine Extends Its Eyes" and Lewis J. Pollock, M.D., professor of neurology and psychiatry, emeritus, at the school, on "The Development of Our Knowledge of Neurology".

DU PAGE

Personal.—Dr. Arthur Rikli, Elmhurst, was recently named to the Board of Governors of the Chicago Heart Association.—Dr. Valdo Oleari, who is associated with the Gieser Eye Clinic in Wheaton, left on January 23 for five weeks in Nigeria, West Africa, where he was going to serve on the board of the Kano Eye Clinic. According to the Elmhurst Press, while Dr. Oleari is in West Africa, Dr. Douglas Hursh, who founded the Kano Eye clinic in 1944, will be spending his two year furlough in the Wheaton clinic. Dr. Kenneth Gieser Dr. Oleari and Dr. Hursh have worked out a rotation system whereby they can donate their services to clinics in foreign lands with no cost to the mission boards. Dr. Gieser has, in the last few years, served on hospital staffs in China, Africa and Pakistan. Dr. Hursh graduated at the University of Minnesota School of Medicine, completing his internship at Presbyterian Hospital in Chicago. He has been chief surgeon and administrator of the Kano Eye Hospital in Niegeria since he founded it in 1944.

GALLATIN

John Doyle Honored.—Dr. John E. Doyle, Ridgway, was one of five physicians recently honored as Silver Anniversary All-Americans named by Sports Illustrated. This was the publication's first such silver anniversary award and the five physicians, four of them surgeons, were among a list of eighty candidates submitted by U. S. colleges and universities.

LOGAN

Society News.—Dr. Raymond Eveloff, Springfield pediatrician, addressed the Logan County Medical Society, January 17, at the Hotel Lincoln on "Respiratory Infection In Children."

MCDONOUGH

Society News.—The film entitled "Grand Rounds on Debatable Tumors", developed by the Upjohn Company, was a feature of the January 25 meeting of the McDonough County Medical Society at the Lamoine Hotel, Macomb.

PEORIA

New Superintendent of Peoria State Hospital.—Dr. Ernest Klein has been officially appointed superintendent of the Peoria State Hospital. The appointment was made by Governor William G. Stratton, effective February 1. A graduate of the University of Illinois College of Medicine, Dr. Klein

has been continuously in state service since July 1, 1937, with the exception of a military leave of absence from November 10, 1942 to July 8, 1946. He has been assistant hospital superintendent at Elgin State Hospital since December 6, 1953. Dr. Klein succeeds Dr. Daniel A. Manelli who is being appointed assistant superintendent of Elgin State Hospital, where he will embark on a special training program. Dr. Manelli has also been in state service since 1937.

LOGAN

Collection of Osleriana.—The reading of "The Life of Sir William Osler", Harvey Cushing's Pulitzer Prize winner, while enroute home from the ETO, launched the avid interest of Dr. Donald M. Barringer, Lincoln, in everything pertaining to Osler, an interest that has resulted in a unique collection housed in his office.

While Dr. Barringer terms his collection "a very modest one when one considers the tremendous amount of material Osler published during his lifetime," persons who have viewed it consider it outstanding. Included are ten of the sixteen editions of Osler's Principles and Practice off Medicine. Many of them are priceless to Dr. Barringer, since they are gifts from older colleagues who knew of his interest in Osler. "The most priceless", he says, is the one belonging to my own father, "One day", he said, "I thought I had come across a first edition, but upon turning to the flyleaf I found the telltale mispelling of Gorgias to be absent indicating that, although the book was a first edition, it was a secor third imprinting."

Dr. Barringer's collection includes a copy of "An Alabama Student," an anthology of Osler's essays. This contains the inscription "To Maggie from a friend, W. O." The writing has been verified as that of Osler both by Dr. W. W. Francis, librarian of the Osler Library at McGill University Faculty of Medicine, Montreal, and Dr. Archibald Malloch. Dr. Francis is also a nephew of Sir William. The identity of Maggie remains unknown.

The collection, which includes twenty volumes and some twenty-five reprints of Osler's original scientific articles, is preponderantly made up of articles and books about Osler. In speaking of this, Dr. Barringer stated that "it is not so much the possession of these items as the friendships and acquaintances I formed in locating them that I treasure. Some of the pleasantest moments of my life have been those spent in conversation with those who knew Sir William Osler intimately—people like Dr. Wilburt C. Davison, Dr. Henry Viets and Dr. Esther Rosencrantz."

The collection occupies the center of a built-in book case in Dr. Barringer's office and is grouped around a plaster head of Sir William done by Doris Appel.

F. Garm Norbury, M.D., Jacksonville, former President of the Illinois State Medical Society, in describing the array, said it was "one of the most unique and interesting he had ever seen."

SANGAMON

Society News.—Dr. John C. Herweg, assistant dean, Washington University Medical School, St. Louis, addressed the February 7 meeting of the Sangamon County Medical Society at the Leland Hotel, Springfield, on "The Newer Antibiotics—Their Use and Abuse."

Memorial Meeting.—The Sangamon County Medical Society held its Fourth Memorial Meeting, January 3, to pay respects to the life work of four members who died within the past several months. The physicians were: Drs. Elizabeth Ball, Harrison C. Blankmeyer, Frank Evans and Vincent V. Mullen. The Reverend Edward W. Ziegler, D.D., conducted the memorial services.

VERMILION

Personal.—Dr. J. A. McSweeny was recently elected into probationary membership of the Vermilion County Medical Society, a custom of the society.

WINNEBAGO

Personal.—Dr. Edward B. Schnell was unanimously elected to membership in the Winnebago County Medical Society recently. Dr. Schnell, a native of Rockford, graduated at Northwestern University Medical School in 1950. On completion of his internship at Cook County Hospital and after serving in the Armed Forces, he served a residency in surgery at Cook County. He is the son of Dr. B. C. Schnell, Sr., of Pecatonica, and the brother of Dr. B. C. Schnell, Jr., Rockford, with whom he shares offices in the Gas-Electric Building. He will limit his practice to general and chest surgery, according to the Bulletin of the Winnebago County Medical Society.

Election of Officers.—Dr. C. B. McIntosh was recently chosen president of the Winnebago County Medical Society. Other officers are: Drs. William H. Palmer, vice-president; L. P. Johnson, secretary; J. N. Frederick, treasurer; and a member of the Board of Directors for a three year term, William K. Ford. Dr. A. C. Meyer was named a delegate to the Illinois State Medical Society for a two year term and Dr. N. L. Sheehe, for a three year term. Dr. B. C. Schnell, Jr., was named to the Board of Censors, and Dr. N. O. Gunderson, Medical-Legal Advisor.

GENERAL

Calling St. Louis City Hospital Alumni.—Dr. Drennan Bailey, secretary of the St. Louis City Hospital Alumni Association, has asked that mention be made of the annual Alumni Association dinner, April 24, at the Le Chateau Restaurant at 10405 Clayton Road, St. Louis County, Mo. Persons interested should contact Dr. Bailey at the Missouri Theatre Building, St. Louis 3, Mo.

Summer Camp for Diabetic Children.—The Chicago Diabetes Association will conduct its summer camp for diabetic children at Holiday Home, Lake Geneva, Wisconsin, July 14-August 4. In addition to the complete camp personnel, the Chicago Diabetes Association furnishes a staff of resident physicians and dietitians, trained in the care of diabetic children. Boys and girls, ages eight through fourteen years, are eligible. For further information regarding the fees, interested persons should be directed to write or phone the office of the Chicago Diabetes Association. Fees will be set on a sliding scale to meet individual circumstances. Physicians are urged to notify parentas of diabetic children and to enter the names of children who would like to attend camp. Applications may be obtained from, and inquiries should be addressed to: The Chicago Diabetes Association, 5 South Wabash Avenue, Chicago 3, Illinois, ANdover 3-1861. Limited capacity requires prompt application.

GENERAL

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:

Julius E. Ginsberg, associate professor of dermatology, Northwestern University Medical School, Chicago High School Council at Harper High School, March 7, on Care of the Skin in Adolescence.

Maurice M. Hoeltgen, Chicago, South Shore Temple Forum, March 8, on Does Society Have a Responsibility for the Health of the Individual?

Sanford A. Franzblau, clinical assistant professor of medicine, University of Illinois College of Medicine, Woman's Auxiliary to the Chicago Medical Society, March 12, on Adding Life to Your Years.

Ben L. Boynton, director of physical medicine and rehabilitation, Oak Forest Infirmary, Oak Forest, Electrical Section, Western Society of Engineers, March 26, on Electronics as Applied to Physical Medicine and Rehabilitation.

Julius Aronow, attending pediatrician at Cook County Hospital, James Monroe Parent-Teacher Association, April 9, on Understanding the Adolescent.

Melvin Krugly, clinical instructor in pediatrics, University of Illinois College of Medicine, Arthur E. Canty School Parent-Teacher Association, April 10, on Health of the School Child.

Howard S. Traisman, clinical assistant in pediatrics, Northwestern University Medical School, McPherson School Parent Education Class, April 16, on Your Child's Health.

Irving Mizell, associate on attending staff of pediatrics at Cook County Hospital, Edison Park School Parent-Teacher Association, April 23, on Problems of Parenthood.

Lectures Arranged Through the Committee on Postgraduate Medical Education and Scientific Service:

Lindon Seed, clinical associate professor of surgery, University of Illinois College of Medicine, and John A. Mart, associate in medicine, Northwestern University Medical School, Winnebago County Medical Society, February 12, in Rockford, on Tumors and Cysts of the Neck and Management of Coronary Disease, respectively.

Louis C. Johnston, Jr., clinical assistant in medicine, University of Illinois College of Medicine, La Salle County Medical Society in La Salle, February 21, on Heart Failure with Emphasis on Treatment.

Bert I. Beverly, Oak Park, instructor in pediatrics, Northwestern University Medical School, Whiteside-Lee County Medical Societies in Sterling, February 21, on Common Pediatric Problems.

Theodore J. Wachowski, clinical professor of radiology, University of Illinois College of Medicine, Champaign County Medical Society in Champaign, April 11, on Diagnostic X-Ray.

Mr. Joseph Stetler, Director, Law Department, American Medical Association, and staff will present a "Mock Trial" before the Will County Medical Society in Joliet, April 11.

Benjamin Blackman, clinical assistant in neurology and psychiatry, Northwestern University Medical School, Stock Yards Branch to the Chicago Medical Society, April 19, on Treatment of the Climacteric by Drugs, Shock Treatment of Psychotherapy.

"Hemo the Magnificent" on television presents unusual pictures of blood.—Some of the most unusual scenes ever shown on television were pictured in "Home the Magnificent," the Bell System Science Series program telecast over the CBS network on Wednesday, March 20. The hour-long program told the story of blood and its circulation.

One section of the film shows the actual flow of blood through the arteries, capillaries, and veins in motion pictures taken through a powerful microscope.

Another sequence, in slow motion, shows the beating of a human heart.

The complicated circulatory system is explained in a simple way by animated sequences that show the circulatory system as something like a public utility.

The heart is the "power house" which constantly pumps a supply of blood to all parts of the body. The arteries, capillaries, and veins are the channels through which the blood flows to the body cells and back to the heart. The brain is the dispatching center. It governs both the rate of the heart in pumping the blood and the distribution of the blood to cells in the brain, muscles, and digestive system.

The program also presents one theory to account for the composition of blood by tracing its evolution from sea water when animal life consisted only of one-celled animals. Another section of the program explains the effect of knockout and shock on the circulation of the blood.

The film, in 16 mm. size, will be available for showing to county medical societies and other groups. Requests should be channeled through your local Bell Telephone Company office.

DEATHS

Ernest Albert Anderson, Rock Island, who graduated at Western University Faculty of Medicine, London, Ontario, Canada, in 1905, died October 14, aged 79. For many years he was medical director for Modern Woodmen of America.

Hiram H. Bay*, Glenview, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1899, died February 1, aged 83. He had served as medical director for two insurance companies.

Michael Francis Dorsey*, retired, Chicago, who graduated at Rush Medical College in 1900, died November 29, aged 85, of broncho-pneumonia. For many years he practiced medicine in Streator where he was on the staff of St. Mary's Hospital.

William V. Haskins*, LaSalle, who graduated at Northwestern University Medical School in 1928, died December 16 following an injury from a fall on December 10. He was 52.

Sally Y. Howell*, Elgin, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1899, died January 31, aged 86.

Robert Wood Keeton*, Chicago, who graduated at Northwestern University Medical School in 1916, died January 22, aged 73. He was professor emeritus of medicine at the University of Illinois College of Medicine; consulting physician at St. Luke's and Henrotin Hospitals in Chicago, and St. Francis Hospital in Evanston; and consulting internist at the Illinois Central Hospital. He was chief examiner of the Chicago subsidiary board of the National Board of Medical Examiners and author of many articles on diabetes, nutrition and physiological research.

Joseph M. Leonard*, Chicago, who graduated at Loyola University School of Medicine in 1925, died February 3, aged 59. He was a member of the staff of Mercy Hospital and medical director for the National Lead Company.

Katherine Levy, Chicago, who graduated at Northwestern University Woman's Medical School in 1899, died October 21, aged 95, of acute myocardial infarction.

Samuel Clifford Lorton*, Shumway, who graduated at Barnes Medical College, St. Louis, in 1906, died November 12, aged 77.

Francis J. McCormick, Chicago, who graduated at Jenner Medical College in 1909, died in St. Anne's Hospital, November 3, aged 80, of bronchopneumonia, cerebral hemorrhage and arteriosclerotic heart disease.

John A. Merideth*, Cobden, who graduated at Washington University of Medicine, St. Louis, in 1927, died in September 1956, aged 55.

C. F. Otto Miessler, retired, Crete, who graduated at the Hahnemann Medical College and Hospital, Chicago, in 1880, died January 15, aged 98. He had practiced medicine in Crete for 73 years.

Mary T. C. Brown Moore, Steger, who graduated at the Hahnemann Medical College and Hospital, Chicago, in 1905, died January 24, aged 71. She was an honorary member of the staff of St. James Hospital in Chicago Heights.

Irving E. Mossmann, Chicago, who graduated at Chicago College of Medicine and Surgery in 1915, died February 5, aged 64. He was a member of the staffs of Michael Reese, Edgewater and American Hospitals.

Isabella Painter Nair, retired, Chicago, who graduated at Chicago Homeopathic Medical College in 1904, in Somerset County, New Jersey, died January 26, aged 93. She practiced medicine in Rogers Park from 1926 to 1950.

Lucille Hammel Snow*, Wilmette, who graduated at the University of Illinois College of Medicine in 1928, died February 8, aged 58. She was a member of the staffs of Mercy, Women and Children's and Illinois Masonic Hospitals of Chicago, and St. Francis Hospital, Evanston.

John E. Walter*, retired, Marathon, Florida, formerly of Waukegan, who graduated at Bennett College, Chicago, in 1915, died January 9, aged 81. He was a life member of the staff of the Victory Memorial Hospital in Waukegan.

Christian H. Zoller*, Litchfield, who graduated at St. Louis College of Physicians and Surgeons in 1903, died October 28, aged 79, of arteriosclerotic heart disease. He was president of the Montgomery County Board of Health and a member of the Industrial Medical Association.

*Indicates member of Illinois State Medical Society.

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*Geiger, E.: Digestion, Absorption and Metabolism of Protein, in Wohl, M. G., and Goodhart, R. S.: Modern Nutrition in Health and Disease, Philadelphia, Lea & Febiger, 1955, pp. 98-143.

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BOOK REVIEWS



TEXTBOOK OF GYNECOLOGY by Emil Novak, M. D., A.B., Assistant Professor Emeritus of Gynecology, Johns Hopkins Medical School; Gynecologist-in-Chief, Bon Secours Hospital, Baltimore; and Past President, American Gynecological Society; and Edward R. Novak, M.D., A.B., F.A.C.S., Instructor in Gynecology, Johns Hopkins Medical School, Gynecologist Bon Secours Hospital and Unison Memorial Hospital, Baltimore. 5th edition, 840 pp. Williams and Wilkins, Baltimore, 1956. $11.00.

This classic of gynecologic teaching has been revised and brought up to date. The original concept of the work — the arrangement by chapters — is retained and the sections dealing with uterine cancer and general tuberculosis have been rewritten.

In the preface, the authors make this statement, significant and characteristic of their acumen, "No final evaluation is as yet possible concerning the treatment of cancer of the cervix nor the still unsettled and rather seething question of carcinoma-in-situ. However, an attempt has been made to discuss this lesion as freely and fairly as possible not only from the standpoint of its pathological differentiation but also present day attitudes toward its management."

There are numerous figures and colored plates illustrating the text. The many diagrammatic illustrations are excellent but many of the reproductions of microscopic section are practically useless.

This complete gynecology adds stature to the library of any student or physician.

C.P.B.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

ANALYTICAL PATHOLOGY: Treatises in the Perspective of Biology, Chemistry and Physics. Edited by Robert C. Mellors, M.D., Ph.D., Associate, Pathology Division, Sloan-Kettering Institute for Cancer Research; Assistant Professor of Pathology, Cornell University Medical College, etc. The Blakiston Division, McGraw-Hill Book Company, Inc., New York, 1957. $12.00.

CARCINOMA OF THE BREAST. By Andrew G. Jessiman, F.R.C.S., M.D., Henry E. Warren Fellow and Assistant in Surgery, Harvard Medical School and Francis D. Moore, M.D., Moseley Professor of Surgery, Harvard Medical School. Little, Brown and Company, Boston. $4.00.

SURGERY IN WORLD WAR II: Orthopedic Surgery in the European Theater of Operations. Editor in Chief: Colonel John Boyd Coates, Jr., M.C. Office of the Surgeon General, Department of the Army, Washington, D.C., 1956. (Vol. 1.)

SURGERY IN WORLD WAR II; General Surgery; Vol. II. Editor in Chief, Colonel John Boyd Coates, Jr., M.C., Office of the Surgeon General, Department of the Army, Washington, D.C., 1955.

A versatile diuretic—the most widely prescribed of its kind—DIAMOX has been found strikingly effective in a variety of conditions, including cardiac edema, epilepsy, glaucoma, toxemia of pregnancy, obesity with edema, premenstrual tension, drug-induced edema following ACTH and cortisone therapy.

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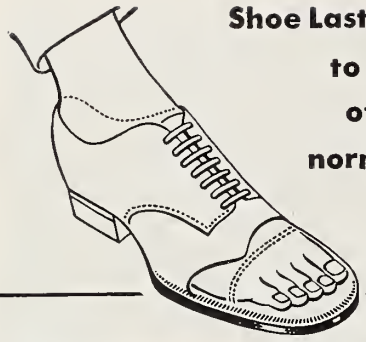


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Seborrheic keratoses

Seborrheic keratoses or seborrheic warts probably are of nervoid origin, and usually make their appearance during the fourth decade. The most common areas of involvement are the face (usually the temple and forehead regions), neck, scalp, and trunk. The first appear as small, slightly raised, circumscribed lesions which, when fully developed, vary from about 5 mm. to 2 cm. in diameter and are light yellowish-brown to black in color. These lesions usually are numerous and new ones appear constantly, resulting in an increase in the size of the growth as well as in their total number. At the onset they are smooth but later become covered with a wax-like layer of keratin and, still later, become verrucous. There usually are no subjective symptoms although slight pruritus may occur. Although these lesions may persist for many years in a benign state, approximately two per cent of the cases eventually degenerate into a basal cell type of malignancy. When malignancy is present, the lesions are soft and friable. Since seborrheic keratoses are superficial lesions, they may be eradicated with mild destructive measures. Freezing for approximately 20 to 30 seconds with carbon dioxide snow is a rapid and effective method which offers excellent cosmetic results. The actual cautery, plus curettage, is another simple procedure which gives excellent cosmetic results. Radium therapy also is effective, with the total dosage varying according to the thickness of the lesions. *Samuel M. Bluefarb, M.D. Precancerous Dermatoses. Geriatrics. Sept.* 1956.

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Cardiac surgical program

National Jewish Hospital at Denver, a free, non-sectarian institution, is expanding its facilities for cardiovascular patients with lesions amenable to surgical intervention. Only patients unable to pay for private care are eligible for admission. Since the hospital has a complete cardio-pulmonary physiology laboratory, definitive diagnosis by the referring physician is not necessary. Inquiries concerning admission should be directed to Miss Grace Grossmann, Director of Social Service and Rehabilitation, National Jewish Hospital, 3800 East Colfax Avenue, Denver 6, Colorado.



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Anesthesia in childbirth

On a well controlled teaching service where patients are cared for by experienced specialists and where the anesthesia is administered by well trainced technicians — usually, in fact, doctor-anesthetists — such an attitude may be comparatively safe. But statistics attest to the fact that this attitude is not without considerable danger. By 1952, anesthesia as a cause of maternal mortality had reached fifth place in New York City, behind hemorrhage, infection, toxemia, and heart disease. By this time, it might well be higher. Turner, describing 79 anesthesia deaths between 1946 and 1954 in Nashville, calls anesthesia "the fourth horseman of the obstetrical apocalypse." An equally impressive title is that of James Herron's in the Bulletin of Maternal Welfare for March and April of 1956, in which he discusses anesthesia as a killer in obstetrics. Twelve per cent of the maternal deaths in Philadelphia from 1949 to 1952 were due to anesthesia, and Fitzgerald and Webster found that no less than 44 per cent of all maternal deaths in three St. Louis hospitals were from anesthesia. Thus, the expressions of apprehension concerning anesthesia continue to grow. Therefore, it is only reasonable to suggest that any obstetric technic which can in any way reduce the amount and frequency of analgesia and anesthesia, and still retain the eminently worth while and charitable objective of relieving pain in childbirth, is of profound practical value, even for this reason alone. *C. Lee Buxton, M.D. An Evaluation of a Prepared Childbirth Program. New York J. Med. Sept.* 1, 1956.

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A diagnostic nip

Complaint of pain in the shoulder, chest, or abdomen coming on soon after taking a small amount of alcohol is suggestive of Hodgkin's disease. Patients known to be suffering from the disease should always be asked about the production or aggravation of symptoms after alcohol; it may enable fresh deposits of neoplastic tissue to be detected at any early stage — before there are clinical or radiological abnormalities — and suitable treatment given. *Editorial. Alcohol-Induced Pain in Hodgkin's disease. Brit. M.J. Sept.* 15, 1956.



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3.7% EFFECTIVE in tropical infections in-uding those complicated by heavy bacte-al contamination or multiple parasitisms.[7]

1. Carter, C. H., and Maley, M. C.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 51. 2. Shalowitz, M., and Sarnoff, H. S.: Personal communication. 3. Shubin, M.: Personal communication. 4. La Caille, R. A., and Prigot, A.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 67. 5. Winton, S. S., and Cheserow, E.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 55. 6. Cornblect, T.: Personal communication. 7. Loughlin, E. H.; Mullin, W. G.; Alcinder, L., and Joseph, A. A.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 63.

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Registered but not comprehended

I have been very interested in the fact that some patients are given information — and very good information — by doctors and yet fail to comprehend what they have been told. On the basis of my experience, I have come to some tentative conclusions. One is that often, if the second examiner is persistent in his inquiries, he will find that the patient really has registered the information. These people, in a sense, act like hysterical young girls who really know a great deal about sex but when questioned, at least initially, deny any knowledge as though it were a foreign topic. In one instance recently, I found that a person who complained bitterly that the doctor had not given her information, really had a wealth of information. This came out only after detailed questioning. She was using very primitive mechanisms. In essence, she was denying the knowledge she actually had. And wherever denial is used, it implies that the patient really knows. On the other hand, there is another group of people who panic with the first mention of surgery. As a result, they actually do not hear anything that follows it. I know it is the general practice of most physicians to state that surgery will be necessary and then wait for the patient to absorb this information before spelling out any details about the nature of the operation, where it will be done, or anything along that line. I think this is a wise procedure. Also, I think the only other thing that can be done along this line — and it is something I'm sure you and others do regularly — is to give the patient plenty of opportunity to ask questions. Unfortunately, it is just the patient who uses denial mechanisms who will not ask questions. *Marc H. Hollender, M.D. Psychologic Problems in Gynecologic Surgery. Somatopsychic Conference. GP, Sept.* 1956.

‹ ›

Veterans administration hospitals are safe places for volunteers to work, so far as danger of getting tuberculosis goes. Although tuberculosis afflicts about one out of every 1,000 persons in the general population, a survey of VA hospitals and other installations showed not one of 11,375 volunteer workers developed the disease after coming on duty. News Item, Sc. News Letter, Nov. 3, 1956.

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Isoniazid in lupus vulgaris

Results obtained with isoniazid in 111 cases of lupus vulgaris are reported after four years' experience with the drug. Improvement took place in all the 103 patients who completed the course of treatment, and in 99 of them the lesions were clinically cleared. In three of the others they have since cleared with other treatment, while the fourth has refused local treatment. The 99 patients whose lesions cleared have been followed for six to 24 months after the completion of their courses. Relapses (with solitary or grouped nodules) have occurred in 11, in whom the average length of treatment was 32 weeks and the average total dosage of isoniazid was 79.5 g. In the 88 patients who have not relapsed, the average length of treatment was 46 weeks and the average total dosage was 108.5 g. Nine of the relapsed cases have cleared again with various treatments and two are improving on a second course of isoniazid. *Brian Russell, M.D. Lupus Vulgaris Treated with Isoniazid. Lancet, Oct.* 20, 1956.



Oh, that—I'm going to 'phone the doctor for an appointment.

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1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc., and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.



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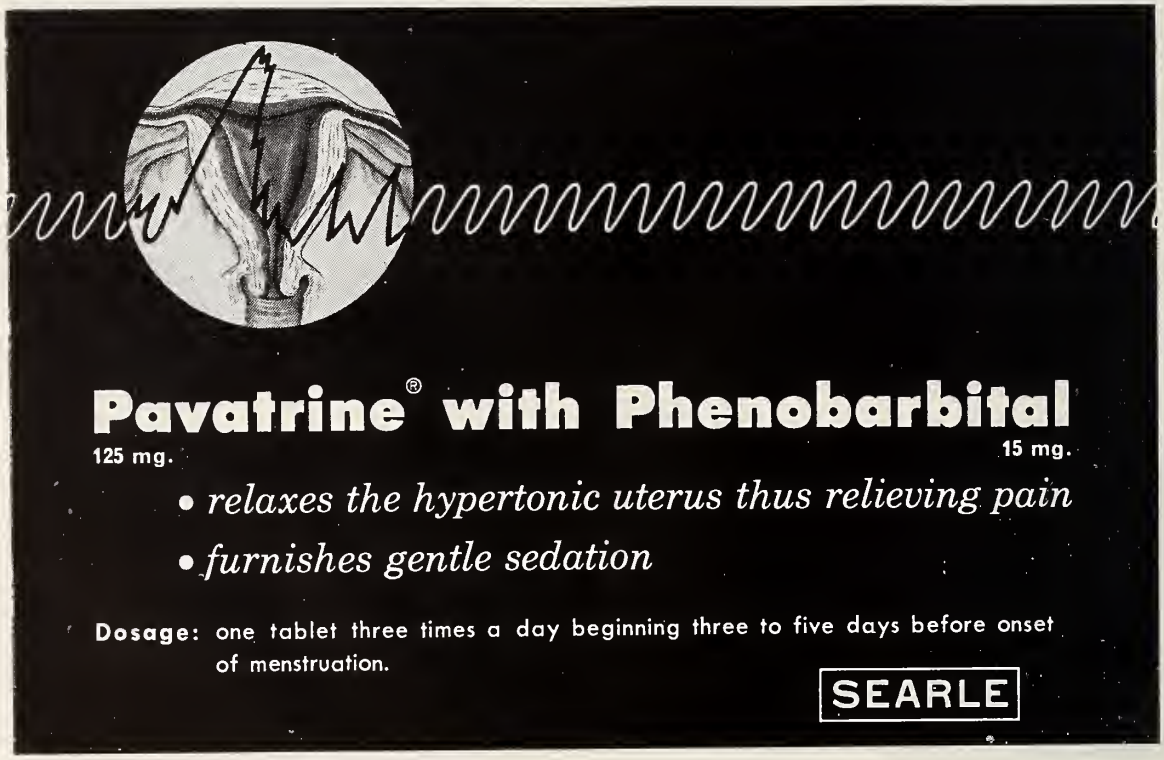
Your Name and Address.

The original gloves

It was the first report on the use of the present rubber gloves used in surgery in Chicago. Heavier, clumsy gloves as compared to these, had been used at Hopkins for some years, but I learned of their use in no other place. I was, for several years, personal assistant to Christian Fenger and at his request, bought the first white cotton gloves used in Chicago after Nicholitz's report on their use. Silk gloves were next tried. It was my mission to locate rubber gloves but it was several months before the gloves now used were located in Akron, Ohio. The little firm making them was thrilled over the thought of a new use for them and offered to send a man to Chicago to make casts of the hands of Dr. Fenger and his assistants to insure perfect fitting of the gloves. In the early use of these rubber gloves, a careful history of each glove was kept. Scrapings from the hands before putting on the gloves and cultures from the inside of the gloves at the end of operations were done by me and turned over to Edward J. Brohm, who did our bacteriology and sectioned specimens for us at the old Passavant Hospital. Cultures from the outside of gloves also were made at the end of operations. Those who have gloves spread at the cuff by the nurse to put them on think little of all the difficulties we, the early users, had in learning how to sterilize, how to store, and keep them sterile, and particularly how to put them on. We first boiled them, which made them soft and lifeless and caused them to tear easily. Later, we tried sterilization by means of the autoclave. For some reasons, perhaps due to the rubber, later improved upon, we had to abandon this method for a time as the inside of gloves stuck when so heated. It was then we started to powder the inside, when sterilizing in the autoclave, but we still filled them with water to put them on because the agglutinated surfaces separated easily when filled with warm solutions. Many were thus torn. Some ingenious nurse showed us how to powder the gloves and our hands and to turn the cuffs well down, and then the nurse spread the cuffs as is done now, whereupon the hands slip in easily and rarely are the

(*Continued on page 74*)

in dysmenorrhea



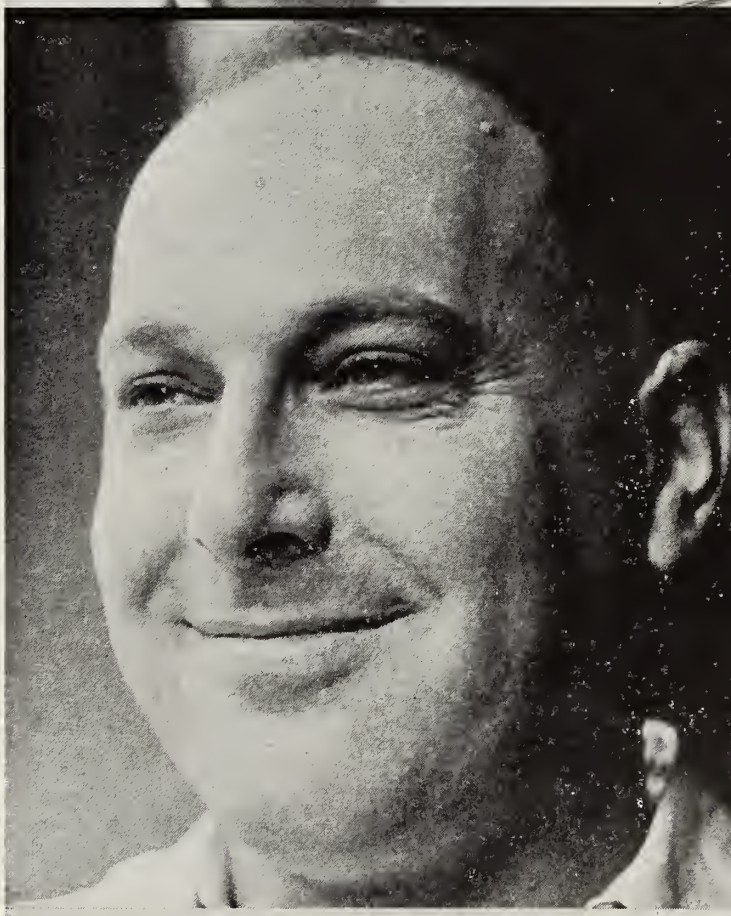
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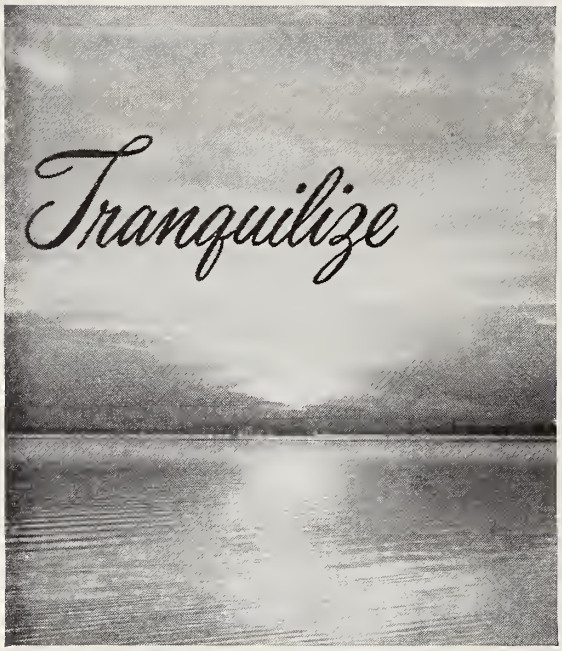
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ORIGINAL GLOVES (Continued)

gloves torn. It must have taken nearly two years to decide upon this method. When the paper, "Rubber Gloves in Surgery" was read at the Chicago Medical Society (1901), both Dr. L. L. McArthur and Dr. Ferdinand Henrotin expressed the belief that they could not be used in surgery because the gloves interfered with the sense of touch. In six months, no one of the living surgeons would think of not using gloves. *Coleman G. Buford, M.D. Communication. Quart. Bull. Northwestern Univ. M. School. Fall* 1956.

‹ ›

The potential suicide

Detailed clinical studies of some hundreds of consecutive cases of attempted suicide admitted to general hospitals have been made recently by Batchelor and Napier in Edinburgh, by Ettlinger and Flordh in Stockholm, and by Schmidt, O'Neal, and Robins in St. Louis, U. S. A. It is clear that suicidal acts form a continuous series, running from superficial gesture intended to manipulate the environment to the determinedly fatal injury. Among younger people a heterogeneous collection of reaction types is found. Many of these patients are temperamentally unstable individuals, unable to solve conflicts in their personal relationships. Batchelor has studied those suffering from psychopathic states, who constitute probably at least one-fifth of those who attempt suicide, and has drawn attention to the repetitiveness and explosiveness of these acts, describing them as suicidal fits. Few of these acts can be forestalled but more attention should be given, he suggests, to such traumatic factors as broken homes in childhood and alcoholism. H. Pozner has given an interesting description of the influence of the military environment on suicidal incidents. Detailed studies of cases of attempted suicide after the age of 60 have been made which, though from different countries, give results that are strikingly in agreement. The attempts usually were serious, all the patients had a clinically diagnosable illness, the large majority were psychotic, and most were suffering from depressions. Once again, the truth of the maxim is seen that in every depressive illness, at every age, there is a risk of suicide. *Editorial. Suicide and Attempted Suicide. Brit. M. J.* Oct. 6, 1956.

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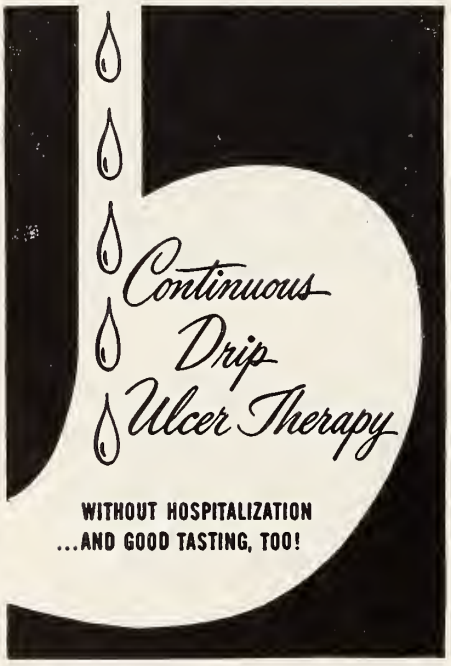


Cortisone versus placebo in asthma

The effect of cortisone acetate tablets was compared with that of placebo tablets in outpatients with chronic asthma, simultaneously receiving routine antispasmodic treatment. Ninety-six patients were studied; 49 in the cortisone group and 47 in the control group. Treatment continued for six months. Particularly as regards diminution of rhonchi and exercise tolerance, there was a partial but significant advantage to the cortisone-treated group during the first eight weeks. From then to the end of the six months, and during three months' followup, this advantage disappeared gradually. *Report. Cortisone Acetate in Chronic Asthma. Lancet, Oct.* 20, 1956.

‹ ›

True progress in law, in medicine — in almost any area of vital human concern — will come from the discovery and cultivation of common interests by people who share a common purpose, unadulterated by special political objectives or ideological differences. Editorial, World Med. J., May, 1956.



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*Steigmann, F., and Goldberg, E.: Ambulatory Continuous Drip Method in the Treatment of Peptic Ulcer, Am. J. Digest. Dis. 22:67 (Mar.) 1955.

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1. Weil, L. L.: J. Florida Acad. Gen. Pract. 4:9 (July) 1954. 2. Williams, Henry L.: J. Michigan State Med. Society 51:572-576 (May) 1952.

The Coxsackie virus

The data are now sufficient to indicate that epidemic pleurodynia, or Bornholm disease, is a Coxsackie virus infection and is usually, if not always, caused by Type B strains. Pleurodynia was perhaps the first clearly defined nosologic entity in which satisfactory evidence for Coxsackie virus as a causative agent was obtained. Thus Curnen, Shaw, and Melnick in 1949 first isolated one of these viruses from a patient with typical symptoms. In 1950 Weller, Enders, Buckingham, and Finn, stimulated by this observation, recovered several strains of Group B virus from stored feces and throat washings collected during an extensive outbreak that occurred in Boston in 1947, and demonstrated increases in homologous antibody during the course of the disease in a number of patients. Similar findings have in general been reported by various authors in this country and in Europe. The most recent correlation between Coxsackie viruses and human disease has been made in cases of a highly fatal myocarditis occurring in infants which is sometimes accompanied by meningitis and encephalitis. In 1952, Gear and his co-workers in South Africa investigated 10 such cases in newborn children. Death occurred in six. Three of these were examined postmortem and acute severe myocarditis was found in each. In the brains of two of the fatal cases, suggestive evidence for the presence of Coxsackie B virus was obtained. An additional small outbreak has been studied by these workers, who subsequently succeeded in isolating a B Type 3 virus from the myocardium of another fatal case. In 1953 Dr. Sidney Kibrick, my associate, recovered in tissue culture the same virus type from the spinal cord of an infant who died five days after delivery by section. Postmortem examination revealed focal myocarditis and meningitis. It is of much interest that the mother underwent a minor illness a few days before the child was delivered. This event, as well as the time relationships, suggests that infection of the infant occurred in utero. Coxsackie A viruses, in contrast to the B group, appear on the whole to be less virulent for man.

(*Continued on page* 82)

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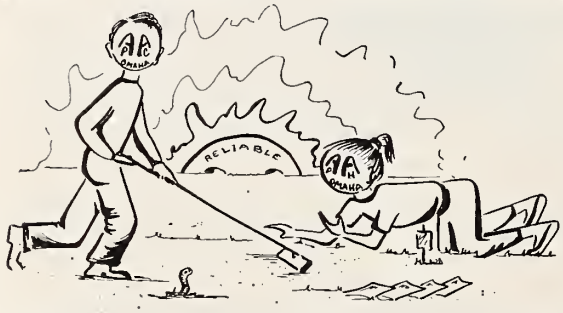
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« »

It is generally accepted that tuberculosis is the most common cause of pulmonary cavitation. That tuberculosis is a frequent occurrence in third-stage silicosis is evident when one considers that over 50% of the conglomerate masses are said to be infected with tuberculosis. Thus, when cavitation occurs in a conglomerate mass, it is usually presumed to be of tuberculous nature. However, the occurrence of nontuberculosis cavitation must not be overlooked. C. S. Morrow, M.B. and R.N. Armen, M.D., Annals of Internal Med., Oct. 1956.

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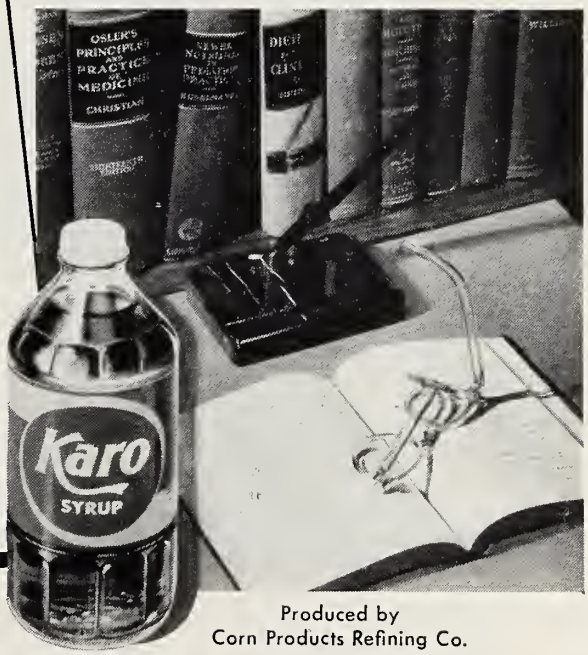
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KARO	1 oz.
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KARO	1 oz.

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Adapted from Nelson's Pediatrics, Saunders, Phila. 1954



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X-ray and leukemia

It can now be accepted without reserve that ionizing radiations can cause leukemia in man. The nature of the relationship between the incidence of leukemia and the dose of radiation, and consequently, an understanding of the scale of risks involved remain to be discovered. It will be of the greatest importance to determine by direct observation, or to predict with some degree of confidence, whether a threshold dose of radiation exists below which exposure is not associated with an increased risk of inducing leukemia. Court Brown and Doll thought that the possibility of very small doses of radiation having a leukemogenic effect could not be ruled out; their further studies, as recently reported by Court Brown to the sixth international congress of hematology at Boston give added weight to the suggestion that over low ranges of dose there may be a simple proportional relationship between the incidence of leukemia and the radiation dose. In such circumstances, no threshold dose of radiation would exist. It may well be, however, that the fetus is more sensitive to the

(*Continued on page* 88)

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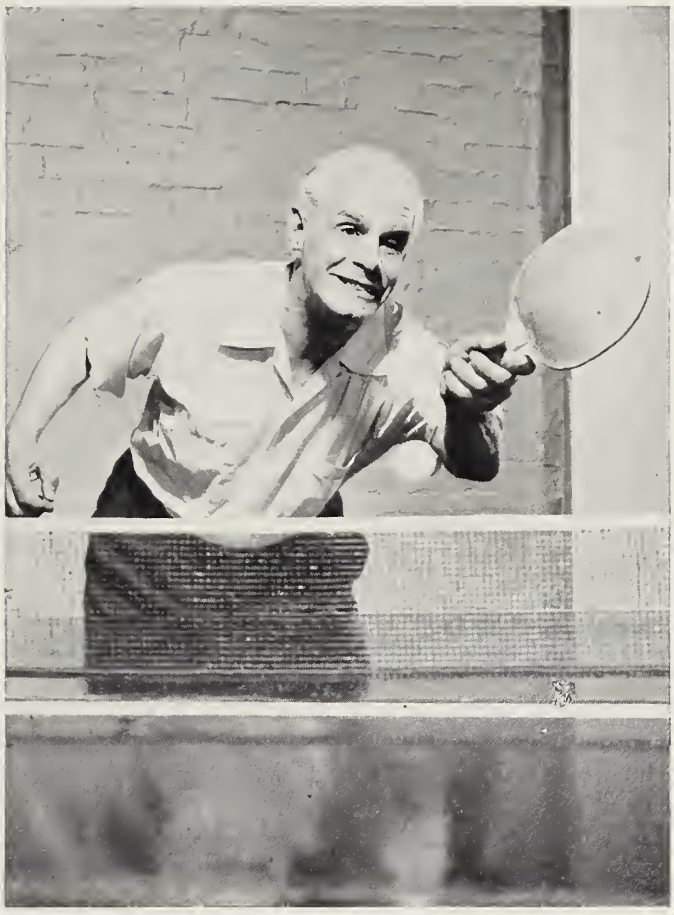
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LEUKEMIA (Continued)

leukemogenic effects of radiation than either the child or the adult. The preliminary results reported by Faber and by Stewart and her colleagues are in keeping with the concept that low doses of radiation, such as are received during diagnostic procedures, may increase the probability of the development of leukemia, but further studies will have to be undertaken to test this hypothesis and to establish it in a convincing manner or to repudiate it on sure grounds. In the meantime, two precautionary steps can be taken. The first is to develop techniques of X-ray examinations which will reduce as far as possible the amount of radiation received during any single exposure, and for this purpose more attention might well be paid to the use of image intensifiers. The second step was clearly stated by the Medical Research Council's committee, which concluded, so far as peacetime hazards were concerned, "that, as all such radiations are potentially dangerous, their use should be the subject of constant and close scrutiny, and that adequate justification should be required for their employment on however small a scale." The findings of Stewart and her colleagues reinforce this plea for "adequate justification," especially for an X-ray examination of the abdomen during pregnancy. *Editorial. Leukemia and Exposure to X-ray. Brit. M.J. Sept.* 22, 1956.

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—*Elbert Hubbard*

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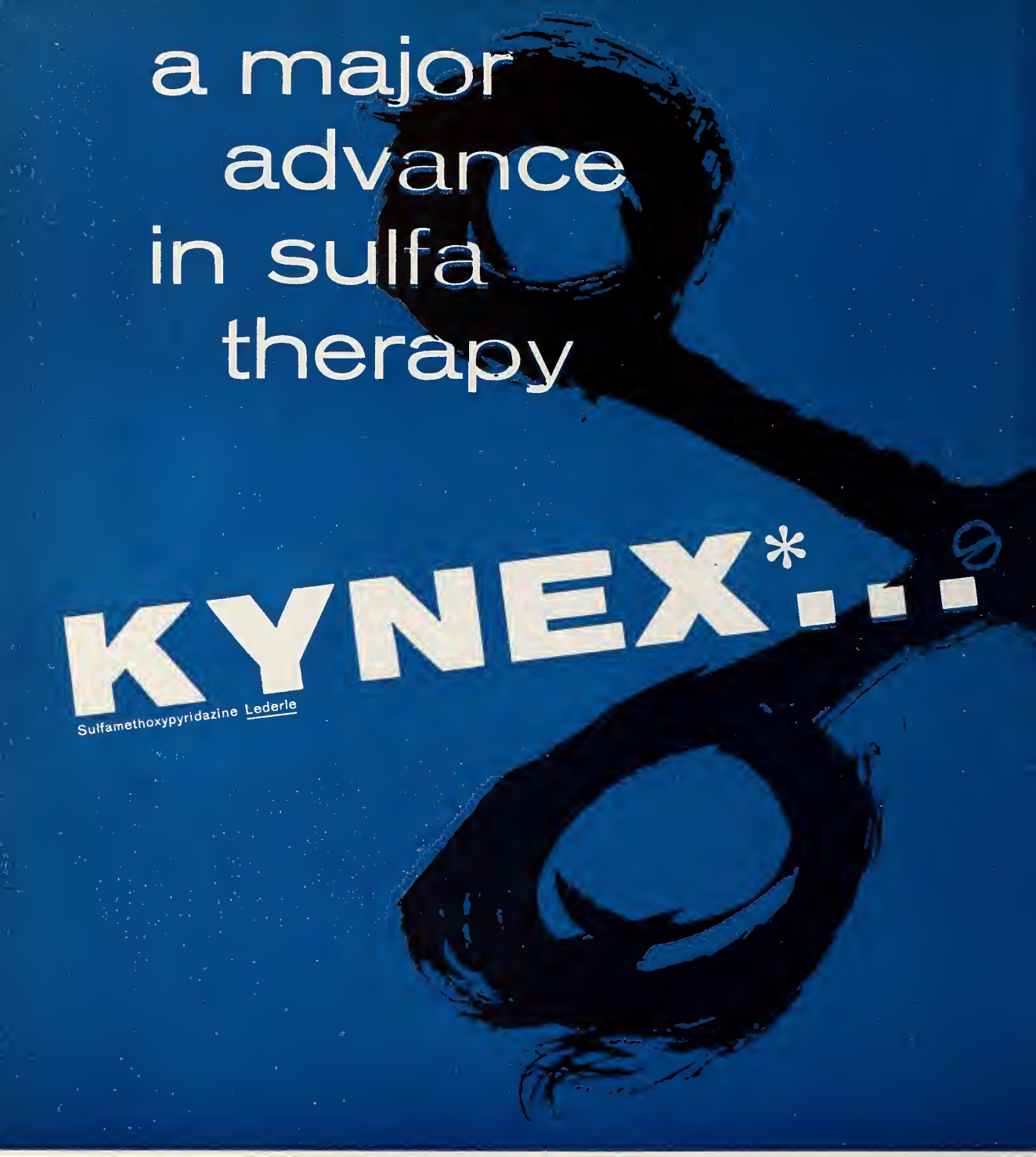
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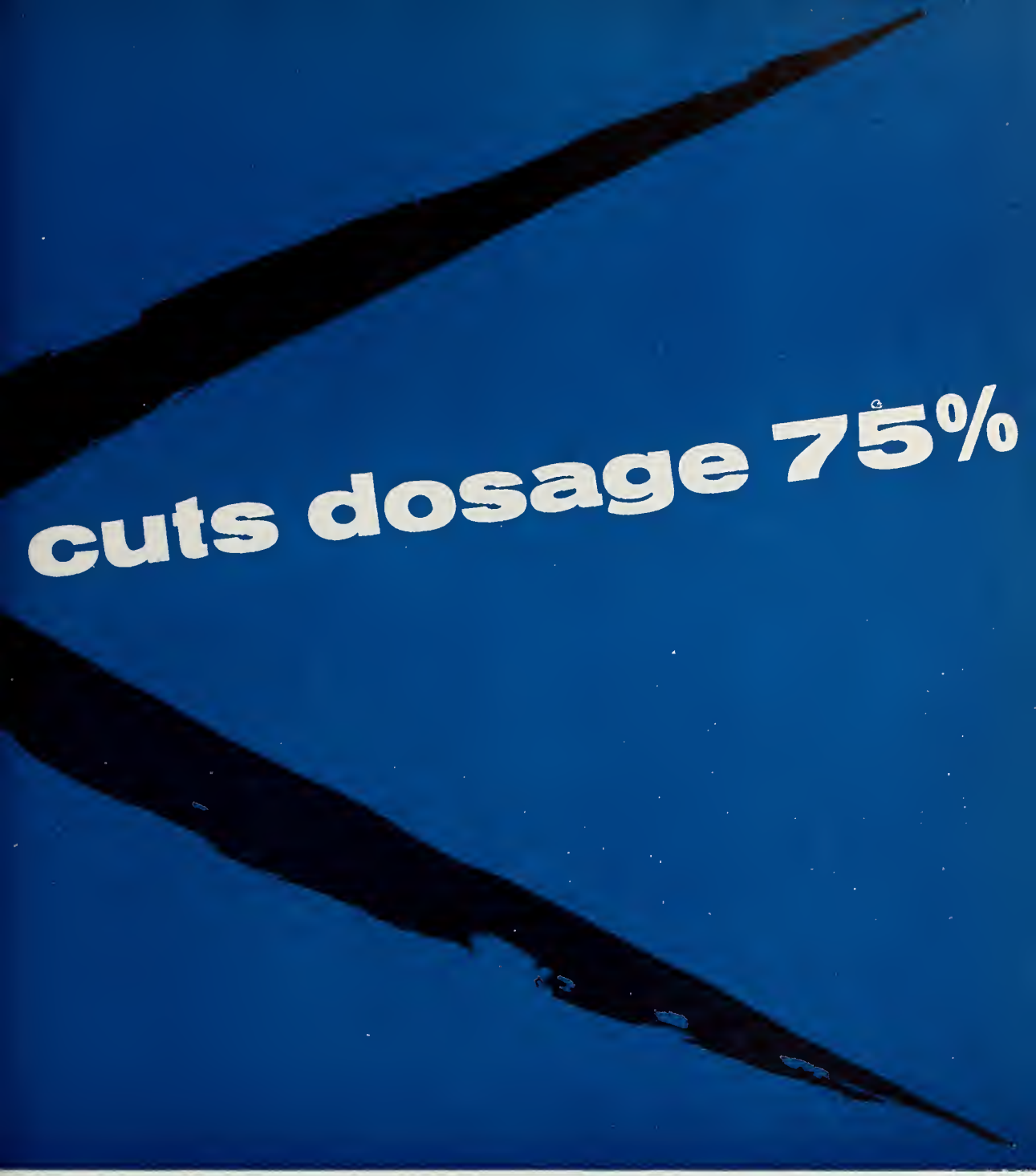
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Prednisolone-Hydroxyzine Combination [ATARAXOID] in Rheumatoid Arthritis

(excerpted from J. M. Soc. New Jersey 54:7, 1957)

PETER J. WARTER, M.D., *Trenton*

Dr. Warter concludes: "The effect of prednisolone on rheumatoid arthritis is enhanced by hydroxyzine, in many instances permitting a substantial reduction in the dosage of steroid . . . of 25 to 50 per cent."

* * *

The intimate correlation between anxiety states and rheumatoid exacerbations suggests that an ataractic agent might potentiate the action of steroids, or provide effective therapy for the emotional components of rheumatoid arthritis. . . . Accordingly, a study was developed to test the idea that combined steroid-ataraxic therapy [ATARAXOID] might be superior to therapy with steroids alone.

* * *

MATERIALS AND METHODS

A total of 6 men and 15 women were available for study. All but one had received steroids previously for rheumatoid arthritis. . . . All patients were started on a dosage of prednisolone equivalent to the amount of steroid they had formerly received: in most cases this was 15 or 20 milligrams of prednisolone daily, in divided doses. In addition, all patients received hydroxyzine [as ATARAXOID]

* * *

RESULTS

Of the 21 patients who completed the trial, it was possible in 12 to reduce the daily dosage of prednisolone when hydroxyzine was given concurrently. Two patients who had been receiving 15 milligrams of prednisolone were maintained on 5 milligrams when the steroid was supplemented by 10 milligrams of hydroxyzine. In eight others who had been receiving 10 to 15 milligrams of prednisolone, it was possible to reduce the steroid dosage by 5 or 7.5 milligrams. . . . Substantial clinical improvement was observed among most of the patients during this study, even among eight of those receiving reduced amounts of steroid. The table indicates the clinical status of the patients at the beginning of the study, and their evaluation after the period of therapy.

* * *

STATUS ON ATARAXOID

Patients	Previous Response Status	Steroid Dose	Clinical Response
1	Poor	R	Imp.
11	Fair	7-R 4-M	7-Imp. 1-Worse 3-N.C.
9	Good	4-R 5-M	6-Imp. 3-N.C.

R: Dose reduced / M. Dose maintained / Imp.: Clinically improved / N.C.: No clinical change.

Three had not been treated with steroids prior to this study. In four patients in the "Imp." group, the improvement was subjective or emotional only.

* * *

In general, the incidence and severity of adverse effects was lower on prednisolone-hydroxyzine therapy than on steroid therapy alone. . . . Therapy was discontinued in two patients because of side effects. In both these cases moderately large doses of steroids were involved.

* * *

SUMMARY

1. Ataraxoid (a combination of prednisolone and hydroxyzine) was used in the management of rheumatoid arthritis in patients whose response to steroids was well-known.

2. Using this combination it was possible to reduce substantially the maintenance dosage of prednisolone in 12 of 21 patients without sacrificing therapeutic effect in any case and with continued improvement in most of the patients.

3. Clinical improvement, reduction of steroid dosage, or both, was achieved in 18 of the 21 patients, and steroid side effects were generally diminished in intensity.

4. Therapy produced a tranquilizing effect in most patients that was not accompanied by drowsiness. In addition it was possible in many cases for the first time to gain the active cooperation of patients in the management of their disease.

This condensation has been prepared by the Medical Department of Pfizer Laboratories as a service to the Medical Profession.

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An additional important therapeutic benefit, often overlooked, stems from the tranquilizing action of meprobamate. This component of MEPROLONE relieves mental tension and anxiety so often manifest in arthritics, making them more amenable to other rehabilitation measures.

INDICATIONS: A wide variety of conditions, in which four symptoms predominate: *a*) inflammation *b*) muscle spasm *c*) anxiety and tension *d*) discomfort and disability; i.e., rheumatoid arthritis, rheumatoid spondylitis (Marie-Strümpell disease), Still's disease, psoriatic arthritis, osteo-

Therapeutic benefits of MEPROLONE compared with traditional antiarthri

	relieves pain	suppresses inflam-mation	relaxes muscle	eases anxiety	imparts sense of well-bei
Salicylates	✓	✓			
Muscle relaxants			✓1		
Tranquilizers				✓1	
Steroids	✓	✓			✓
MEPROLONE	✓	✓	✓	✓	✓

1. Meprobamate is the only tranquilizer with muscle-relaxant action.

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The Month in Washington

Washington, D. C. — The Army's Office of Dependent Medical Care, handling the new program that offers private medical care to service families, is working on some long and some short-range plans of importance to state societies.

To meet a problem coming up in the next few months, the office is notifying states that contracts for physicians' services, negotiated through the state societies last fall, will be extended automatically when their expiration date of July 1 arrives. However, there is no definite time period set for any of the extensions; each contract will be continued in effect until that particular state's agreement has been renegotiated.

When the contract is extended, according to Maj. Gen. Paul I. Robinson, head of the Office of Dependent Medical Care, it will be possible to make necessary adjustments, but he hopes not too many changes will be asked at that time.

Then, after July 1, each state will be given 60 days' notification before Defense Department makes its final audit covering the period from December 7, 1956, when the program went into effect, through June 30, 1957. This audit has been promised in each state before renegotiation starts.

Both the state fiscal agents and Gen. Robinson's staff should be well prepared for renegotiations when the time arrives. No renegotiations will be undertaken until January, 1958. They will continue for most of next year, on a tentative schedule that calls for handling about five contracts per month.

Under this tentative arrangement, the contract with the Illinois Medical Society will be renegotiated during the month of July.

If any large-scale health and medical program is to be pushed through Congress this year, most of the pushing will be done by the Democrats, who, in control on Capitol Hill, can get what they want, in theory at least.

Announcing that the idea of a special presidential health message had been dropped for this year, Secretary Folsom also said the Republican administration would press for only three major health-medical bills. All three, incidentally, were before Congress last year but were not acted upon. They are:

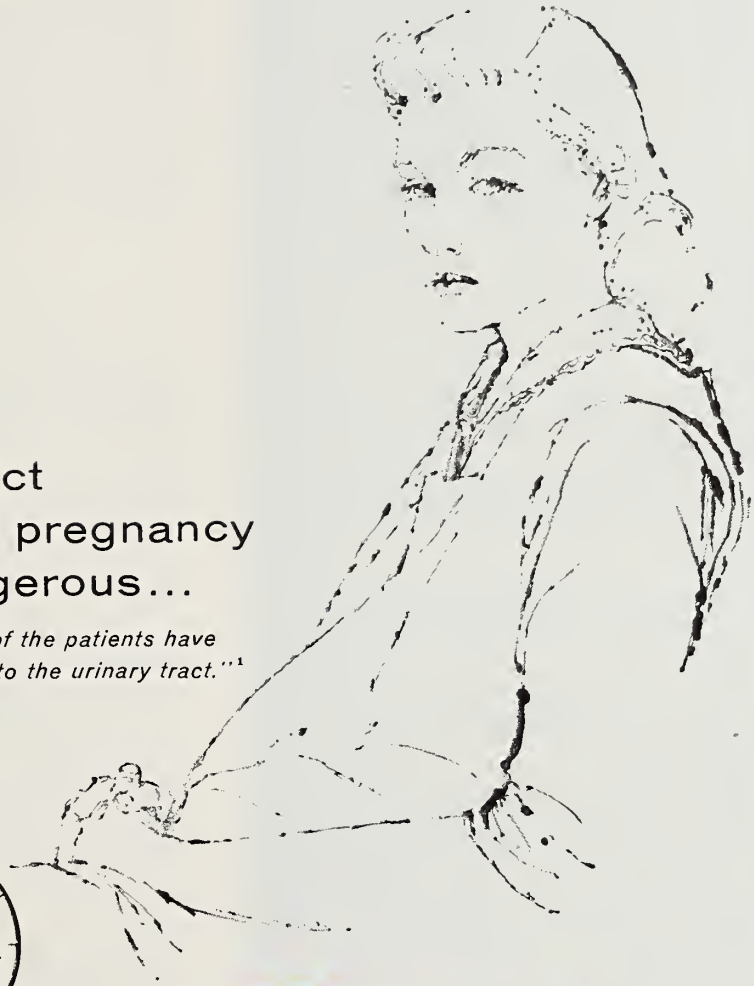
1. Federal assistance to medical, dental, and public health schools to help them build and equip new teaching facilities or improve and expand existing classrooms or labs.

2. Waiver of the anti-monopoly laws to permit small companies (none doing more than one percent of the total business) to pool some of their funds for experimental work in expanding voluntary health insurance.

3. Authorization for construction of sanitary facilities on Indian reservations.

In outlining these legislative objectives of the administration, the Secretary took the opportunity to make clear he doesn't think much of one bill that has the ardent support of some Democrats and of some labor leaders. It would have the U. S. pay for 60 days' free hospitalization annually for persons aged 65 and over who are under social security, and their dependents if also over 65.

(*Continued on page* 30)



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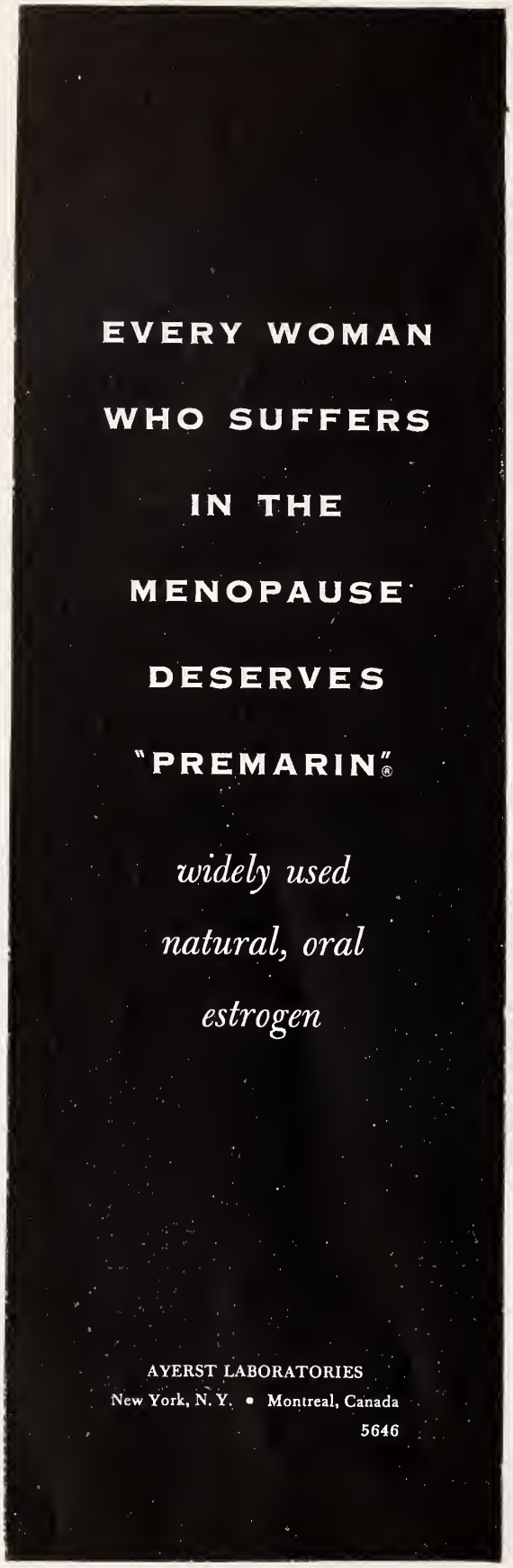
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REFERENCES: 1. Rives, H. F.: Texas J. M. **52**:224, 1956. 2. Diggs, E. S.; Prevost, E. C., and Valderas, J. G.: Am. J. Obst. **71**:399, 1956. 3. MacLeod, P. F., et al.: Internat. Rec. Med. **169**:561, 1956.

NITROFURANS

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WASHINGTON (Continued)

Mr. Folsom said the social security administration has all it can do administratively to put into effect the major amendments passed last year, and that besides the "hospitalization at 65" plan skirts so close to the area of compulsory health insurance that it should be regarded cautiously.

NOTES

A House committee making a survey of the cost of veterans' programs, has been asked by VA Administrator Harvey Higley to ponder this question: Should more VA hospitals be constructed when we know beyond doubt that they will be largely for the benefit of non-service-connected cases?

As anticipated, pressure already is on Congress to drop or lower the age 50 limit for OASI payments because of disability. Many bills have been introduced on the subject.

Congressmen are hearing again from the friends of the "Hoxsey cancer cure", which has been under constant attack by Food and Drug Administration but still manages to stay in business. Form cards, carrying space for a name and address, are being received on Capitol Hill, each asking Congress to investigate FDA for the way that agency has pressured the Hoxsey people.

An addition to the top echelon of the Department of Health, Education, and Welfare is a young (33) assistant to Secretary Folsom, who holds both medical and law degrees. He is Dr. Robert H. Hamlin, of Brookline, Mass. Another HEW addition is John A. Perkins, Ph.D., president of the University of Delaware, the new Under Secretary.

‹ ›

Some were pooped

In a study of a number of industrial workers, Lillian Gilbreth noted an interesting fact. At the end of the day, some of the men were ready to drop with fatigue. Others were full of bounce. Yet all had done the same work for the same length of time. The mystery? None — except that the lively ones had one thing in common. They were looking forward to some sort of evening activity. *William Sherman, M.D. How Not to Get Pooped. J. Stud. A.M.A. Oct.* 1956.

The
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APRIL, 1957
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A Clinical Evaluation of Penicillin V in Children with Respiratory Infections

Ronald M. Mack, M.D.,* and Joseph R. Christian, M.D.,† Chicago

PHENOXYMETHYL penicillin represents a new form of oral penicillin therapy. It is produced biosynthetically by Penicillium Chrysogenum C 9216 in a culture medium containing a special nutrient substrate. Unlike penicillin G, it is acid stable and suffers no destruction by the acid gastric secretions in its passage through the stomach.[4] Thus, more antibiotic is availiable for absorption from the upper intestinal tract. Penicillin G is destroyed by the gastric acids and this presumably can result in a decreased or variable response when the medication is given orally in severe infections. Penicillin V, however, is soluble in the alkaline medium of the small intestine, thereby making it unnecessary to prepare metallic or organic salts of penicillin V acid for oral use. These metallic or organic salts, being more soluble than the free acid form at low acid pH levels, are inactivated more rapidly.[1] At pH 5 and below, penicillin V is far more stable than penicillin G. With the pH of gastric contents normally ranging between 1-2.5, penicillin V is relatively insoluble, thus enabling it to withstand acid gastric secretions. Penicillin V differs from penicillin G by only one oxygen atom;[2] however, on a unit-for-unit basis, using Micrococcus pyogenes as the test organism, the V form is more active than the G.[1]

The main indication for penicillin V is infection caused by bacteria that are susceptible to the drug, principally streptococci, pneumococci, gonococci, and sensitive strains of staphylococci. Effectiveness of the drug in several cases of subacute bacterial endocarditis recently has been shown [1,2]

The purpose of this paper is to present the results of clinical observations on 54 children with common respiratory infections, treated with penicillin V.

SUBJECTS AND METHODS

Fifty-four infants and children ranging in age from several months to 13 years were studied. Patients were observed as in-patients, out-patients, or both. The laboratory workup consisted of a throat culture and white blood cell count prior to the initiation of therapy. Rectal temperatures were recorded on all patients every six

*Resident Physician, †Associate Professor, Department of Pediatrics of the Stritch School of Medicine of Loyola University and Mercy Hospital, Chicago, Illinois.

hours. The mothers of the out-patients studied recorded the temperatures during the course of therapy.

All penicillin V was given orally in a palatable preparation* containing 125 mg. (200,000 units) per teaspoon every six or eight hours, irrespective of the size or age of the patient, but dependent upon the severity of the infection as observed clinically.

The majority of the patients studied (61 per cent) were under five years of age; and only 7.4 per cent were over ten years of age.

TABLE 1
AGE INCIDENCE

Age	No. of Cases	Age	No. of Cases	Age	No. of Cases
0-6 mos.	5	4-5 yrs.	3	9-10 yrs.	1
6-12 mos.	7	5-6 yrs.	5	10-11 yrs.	2
1-2 yrs.	5	6-7 yrs.	5	11-12 yrs.	0
2-3 yrs.	8	7-8 yrs.	3	12-13 yrs.	2
3-4 yrs.	5	8-9 yrs.	3		
	30		19		5

Acute tonsillitis alone or in combination with otitis media was the most common clinical manifestation of respiratory disease seen in this group. However, pneumonia was seen alone 4 times and in combination with tonsillitis or pharyngitis, 3 times.

TABLE 2
TYPE OF DISEASE

Disease	*Number of Cases*
Acute tonsillitis and/or pharyngitis	29
Acute tonsillitis and/or pharyngitis with acute otitis media	17
Pneumonia	4
Pneumonia and acute pharyngitis or tonsillitis	3
Acute otitis media	1
	54

Eight cases in the series were found to have beta hemolytic streptococci; three, staphylococcus aureus, and one, diplococcus pneumonia. The remaining throat cultures revealed a multiplicity of organisms as indicated in Table 3.

In 25 of the patients observed the total white blood cell count was over 10,000 and in 18, below 10,000.

TABLE 3
LABORATORY STUDIES

I. *Bacteriology (Throat Culture)*	*Number Of Cases*
Alpha hemolytic streptococci	13
Beta hemolytic streptococci	8
Staphylococcus aureus	3
Diphtheroids	2
Pseudomonas aerogenes	2
Diplococcus penumoniae	1
Neisseria catarrhalis	1
Staphylococcus albus	1
Tetragenes	1
Normal (no growth)	11
Not cultured	11
	54

II. *White Blood Cell Count*	*Number Of Cases*
Above 10,000	25
Below 10,000	18
Not determined	11
	54

The clinical response of the patients to medication was graded as: marked improvement, improvement, or failure. Marked improvement denoted defervescence, improvement of symptoms, and feeling of well being within 24-48 hours. Improvement denoted lessening of clinical symptoms, defervescence, and a feeling of well being within 48-96 hours. There was marked improvement in 54 per cent, improvement in 40 per cent, and failure in 6 per cent. Failures were found in the group of patients treated as out-patients. No cultures were taken on these patients, thereby suggesting the possibility that organisms were present that were not sensitive to the antibiotic. Additional therapy with another medication was necessary in two of these and a second course of penicillin was successful in one of the failures. Best results were obtained in the streptococcal group of infections. A remarkably good response in the pneumonias confirmed results noted previously by other authors.[1] Oral moniliasis, that has been reported with the administration of penicillin orally, occurred in one case. Diarrhea appeared in one patient as the original infection subsided, suggesting a reaction to the drug.

*V-Cillin Pediatrio,® Eli Lilly and Company, Indianapolis, Indiana

TABLE 4
RESPONSE TO MEDICATION

Marked Improvement	54%
Improvement	40%
Failure	6%
Coincidental side effects	3.7%
a) Oral moniliasis (1 case)	
b) Diarrhea (1 case)	

CONCLUSIONS

Penicillin V is a drug which can be administered orally and appears to be safe and efficient for use in treating the more common respiratory infections of infancy and childhood. Being acid stable, there is no destruction by the acid gastric secretions in its passage through the stomach. Therefore, a higher and more constant blood level should be attained. Although larger doses have been administered in previous studies, the results in our group help to confirm clinically this concept of less destruction and greater absorption.

SUMMARY

Penicillin V was administered to 54 pediatric cases with acute respiratory infections. The majority improved with the administration of penicillin V in a dosage of 125 mg. every six to eight hours. Throat cultures revealed a multiplicity of organisms. Leukocytosis was found in 25 of the 54 cases.

Fifty-four per cent showed marked improvement; 40 per cent, improvement; and 6 per cent, failure. One case of moniliasis and one of nonspecific diarrhea developed while on the medication.

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Management of pancreatitis

The nonsurgical, conservative approach to the handling of acute pancreatitis is generally accepted as giving the best results. This is particularly true in the interstitial form which usually ends in recovery but it also is true of the hemorrhagic form. Yet when the mortality in this latter variety approaches 15 to 20 per cent, one cannot help but wonder if conservative treatment is sufficient. Obviously some of the cases cannot be salvaged under any treatment, but there is always the small group of patients who seem to be recovering and then suddenly get much worse and die. It is in these patients that we are beginning to offer surgery, particularly if a mass develops, if the peritonitis seems to be spreading, if signs of toxicity increase, or if the patient obviously is not improving. Multiple avenues of drainage are established to allow for the escape of treachcrous fluids and this alone benefits many of these acutely ill patients. It might be wise to establish biliary decompression at the time of drainage but we have not done this additional procedure as we feel we should do as little as possible at this critical period of the disease. *Robert C. Lee, M.D. Advances in Surgery of the Pancreas. Missouri Med. Sept.* 1956.

Adult Agammaglobulinemia

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ABOUT two years after Bruton's description in 1952 of a gamma globulin defect in a 9 year old boy, Sanford reported the first agammaglobulinemia in an adult. Since then 23 cases have appeared in the literature and the authors are unanimous in their impression that immunoglobulin deficiency in adults is not at all uncommon. The clinical syndrome is striking and confirmation of the diagnosis is easy.

Commonly identified diagnostic criteria are as follows:

1. History of repeated bacterial infections.
2. Failure to develop immunity after adequate antigenic stimulus.
3. Absence of normally inherited isohemagglutinins.
4. An abnormally low serum globulin concentration.
5. Electrophoretic demonstration of complete absence of gamma globulin fraction.

The importance of being alert to and discovering this anomaly is reflected in the clinical course of patients now on gamma globulin replacement therapy. Formerly infection prone semi-invalids, these individuals regain essentially normal health on bi-weekly injections of gamma globulin.

The following is a case report of a young adult with agammaglobulinemia.

The patient, a 32 year old white male postal clerk, was seen in April, 1955, because of fever, cough, and pleuritic chest pain. The patient had enjoyed good health prior to and during a four year tour of duty in the armed services. In 1947, about one year after discharge, he contracted a febrile illness diagnosed as pneumonia. Recovery was apparently uneventful. During the subsequent eight years, however, he experienced, in relatively rapid succession, six separate proved cases of lobar or bronchopneumonia, two bouts of mumps, several attacks of acute gastroenteritis, cellulitis of the hand, chronic suppurative maxillary sinusitis, innumerable episodes of influenza, tonsillitis, and common colds. Bacterial infections apparently responded quickly to antibiotic therapy.

In 1951, subsequent to one of the illnesses, an examiner noted splenomegaly, some rubbery, almond-sized axillary lymph nodes, and a blood count of 3.8 million red cells, 11.9 grams hemoglobin, and 4,400 white cells. Although these findings were not explained, during the following four years, anemia cleared without treatment and adenopathy receded but the spleen remained enlarged.

Physical examination in April of 1955 revealed a slender, flushed young man who appeared acutely ill. Temperature 101, pulse 90, blood pressure 110/70. Positive findings were limited to signs of pneumonia in the right upper lobe and a firm, nontender spleen enlarged 4 cm. below the left costal margin on deep inspiration. No significant adenopathy was found and the liver was thought to be of normal size. The remainder of the physical examination was within normal limits.

Chest X-rays confirmed the presence of pneumonic process in the right upper lobe. Repeated sputum studies for acid-fast bacilli were negative and the patient recovered rapidly with antibiotic therapy.

Because of the history of an unusual number of viral and bacterial infections, further investigative procedures were undertaken. The red blood count was 4.5 million and the hemoglobin 14.2 grams %. Total white blood cells were 5,000 of which 73% were PMN's, 23% were lymphocytes, 3% were monocytes, 1% eosinophiles. Urinalysis was normal and Kahn negative. Total serum proteins were 6.1 grams of which 5.5 grams were albumin and 0.65 grams were globulin. Liver function tests were all within normal limits and a blood culture was negative. Bone marrow aspirate was interpreted as showing moderate erythroid hyperplasia but was otherwise normal. No plasma cells were seen.

The patient had Type A blood but possessed anti-B isoagglutinins only through a 1:2 dilu-

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tion. The Coombs test was negative. The heterophile agglutiation was negative and the "O" and "H" typhoid and the A and B paratyphoid were negative prior to and also three weeks after routine immunization with typhoid-paratyphoid vaccine. Histoplasmin, coccidioidin, and P.P.D. skin tests were all negative and the mumps skin test antigen elicited no response despite the fact that the patient had experienced his second bout of mumps eight months previously.

A Tiselius boundary electrophoretic study*, using the patient's plasma, (Figure 1) demonstrated complete absence of gamma globulin and depression of the beta fraction. In the several months that elapsed before an adequate supply of gamma globulin could be obtained, the patient developed bacterial or viral illnesses severe enough to warrant medical attention on the average of every two to four weeks. A recurrent suppurative sinusitis withstood all conservative therapeutic measures.

On February 11, 1956, 15 cc. of commercial gamma globulin solution (equivalent to 2.5 grams of gamma globulin)** were administered intramuscularly. Plasma samples taken six days later failed to demonstrate any gamma globulin, although the patient responded well clinically. Low grade fever disappeared, sinusitis cleared, appetite improved, and he gained weight. Two weeks after the first injection, the patient was given 4.1 grams (25 cc.) of gamma globulin. Twenty-four hours later, blood samples indicated a slight rise in the total globulin fraction but again, no detectable gamma globulin appeared on the electrophoretic tracing. Up to the present time the patient remains healthy and is receiving bi-weekly injections of gamma globulin.

DISCUSSION

The etiology of this anomaly is far from clear. In children with this defect, the history of inadequate antibody formation since infancy points to a hereditary genesis thought to be sex-linked. In adults, however, the majority of patients lead apparently healthy lives until the abrupt appearance of the syndrome in the second to sixth decade. Although three cases appear intimately associated with a serious systemic disease such as a lymphoma or multiple myeloma,

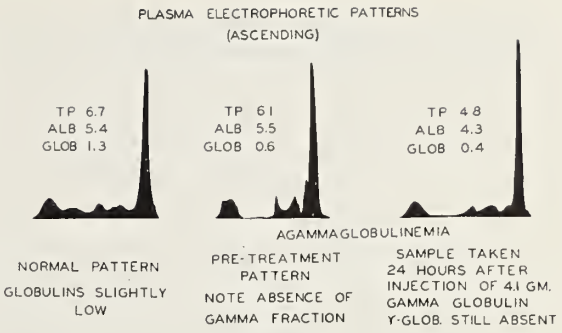


Figure 1

the great majority clearly represent primary deficiency states.

Half-life experiments using I^{131} labeled gamma globulin in patients with agammaglobulinemia have demonstrated normal to slightly prolonged life span of the injected globulin. Hence, it is felt that the defect lies in impaired synthesis rather than accelerated catabolism.

Perfusion studies show that although all of the fibrinogen and albumin is synthesized by the liver, only 80% of the globulin originates there. Hepatectomized animals produce globulin but no albumin. Antibodies have been shown to be a heterogeneous group of globulins primarily of the gamma mobility. It is known that lymph nodes and the spleen can form antibodies.

Adult lymphocytes have been found to contain normal gamma globulin and it is known that antibodies and other globulins of slow electrophoretic mobility are produced by plasma cells. The cellular source of gamma globulin is still controversial but most investigators favor the mature lymphocyte or the plasma cell. Rohn and Brehm believe that absence of plasma cells in the bone marrow aspirates and biopsy specimens of their patients is significant while Bruton, Janeway and Young stress their findings of lymphopenia, absence of lymph node germinal centers, and lack of tissue lymphocytes. In the case presented today, lymphocytes were found to be quantitatively and morphologically normal while plasma cells were conspicuously absent.

A striking finding in reviewing reported cases of agammaglobulinemia in the adult was that four investigators reported cases of the gamma globulin defect associated with pancytopenia necessitating splenectomy or irradiation of the spleen. Hematological recovery occurred in each case.

Generalized lymphadenopathy and spleno-

*Performed at the University of Illinois department of chemistry through the courtesy of Carl Vestling and assistance of Mr. Tao Huang.

**Supplied by Lederle Laboratories, Pearl River, New York

megaly were common findings but no single explanation is as yet fully accepted. An apparently popular and attractive theory postulates that in the absence of antibodies there is a compensatory hyperplasia of the phagocytic elements of the reticuloendothelial system in response to infection. In one case, study of the splenic tissue showed marked increase in the highly phagocytic clasmatocytes containing great numbers of phagocytized red blood cells, white blood cells, and platelets. Although the author finds no evidence of hypersplenism in this patient at the present time, the findings of unexplained anemia, splenomegaly, and leukopenia two years ago tempt incrimination of such a phenomenon.

Of the several cases followed for more than three years, no spontaneous remissions have been observed and the gamma globulin defect must be considered permanent. It is neither practical nor necessary to achieve complete replacement. It has been estimated that 25 cc. of the 15% gamma globulin solution (usual commercial form) would have to be given daily to restore normal circulating levels of gamma globulin.

Since intravenously administered globulin produces severe hypotensive reactions, the subcutaneous or intramuscular route must be utilized. Half-life studies with I^{131} labeled gamma globulin and clinical observations indicated the need for globulin supplements at least every 14 days in adults with agammaglobulinemia. Amounts given at bi-weekly intervals vary with the authors between 0.1 gm./kg. — 0.05 gm./kg. Since the virus of homologous serum hepatitis is not associated with the gamma globulin fraction, there is little danger of hepatitis even with prolonged therapy.

SUMMARY

An additional case of adult agammaglobulinemia has been described, demonstrating the classical inadequate resistance to infection, lack of antibody formation, and absence of the gamma globulin fraction on electrophoretic tracings. The patient is currently maintained in good health by bi-weekly injections of gamma globulin. Pathogenetic theories are discussed. With filter paper and starch block electrophoresis becoming more widely available, the author feels that many more cases of this deficiency state in adults may be diagnosed and successfully treated.

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Cushing's Syndrome

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CUSHING'S original publication[1] set off a train of investigations and debates, which is still going on, as to the cause of this syndrome. While it occurs in connection with a number of conditions, it is now generally admitted that it does not exist without an overproduction of the adrenal cortical hormones — the 11-17-oxygenated steroids. The adrenal glands may be normal in size and appearance, hyperplastic, or the site of adenoma or carcinoma. It has been suggested that this over production is due to a basophil adenoma of the anterior pituitary, to some disturbance of the hypothalamic area, or to some disturbance within the adrenal itself. Jailer et al.[2] recently suggested that the pituitary secretes a corticotropic potentiating hormone which is responsible for the condition. They feel that this hypothesis comes more nearly than any other to satisfying the various requirements of this problem. In some respects this syndrome resembles Graves' disease.

The disease attacks women more often than men in the ratio of about 5 to 1. It is said to be a rare disorder. There is reason for doubting this and for believing that many cases, particularly milder forms, are overlooked. The case reports forming part of this contribution are designed to emphasize this point of view.

Four American (Soffer[3]; Williams[4]; Paschkis, Rakoff and Cantarow[5]; Hurxthal and Musulin[6]) and one English textbooks (Greene)[7] list the following signs and symptoms:

1. Obesity
2. Hirsutism - virilism
3. Amenorrhea or oligomenorrhea

Other symptoms and findings include: purplish striae, hypertension, disturbances of carbohydrate metabolism (or diabetes), osteoporosis, impotence, moon facies, plethora, cervical fat pad, "buffalo" hump, asthenia, headache, backache, polydipsia and polyuria, edema, psychological changes (depression), acne, skin pigmentation, poor wound healing, hemorrhagic manifestations, exophthalmos, pathological fractures, enlarged clitoris, electrolyte changes, and convulsions.

Thorn and Forsham[8] summarize the situation as follows: "The presence of at least three of the following strongly suggests the diagnosis: extreme weakness and muscle wasting; obesity sparing the extremities; osteoporosis; hypertension; striae (red and depressed); diabetes mellitus. However, rare instances of only one presenting symptom or sign are on record, such as diabetes mellitus or osteoporosis."

The diagnosis is based on the clinical appearance of the patient: The ruddy moon-shaped face, the cervical dorsal or "buffalo" hump, the peculiar obesity involving the face and trunk and sparing the extremities, and the cutaneous striae; and the laboratory findings. The glucose tolerance test will often show a diabetic type of curve. Eosinopenia, lymphopenia and a higher than normal hematocrit also should be found. The output of 17-ketosteroids and total corticoids in the urine is sometimes greater than normal. The amount may be greatly increased by the eight hour intravenous infusion of 25 units of ACTH. This maneuver may not cause any increase if a cancer of the adrenal is present.

A flat plate of the abdomen or an intravenous pyelogram will sometimes show suspicious shadows in the region of the adrenal or displacement of the kidney. Later in the case, the skeleton shows signs of demineralization. Perirenal or presacral insufflation of air about the kidney region is used by some and decried by others. In our limited experience it has been of no value. There are many objections to it. Probably when suspicion is great enough to warrant use of that procedure, it would be better to explore the adrenals.

One has to think of the adreno-genital syndrome, which also is due to hyperfunction of the adrenal cortex. It is characterized by hir-

sutism, enlarged clitoris, atrophy of the breasts and frequently a loss of hair on the head. The current idea as to its cause is that the adrenals have lost the ability to convert 17-hydroxyprogesterone to 17-hydroxycortisone. The reduction in the latter leaves the pituitary uninhibited so that it bombards the adrenals with additional amounts of corticotropin causing them to put out more 17-hydroxyprogesterone, which produces the signs of virilism. Hirsutism is too often and with too little study assigned to the limbo of genetic or idiopathic. Kappas et al.[9] have recently made a valuable contribution to our knowledge of this subject. In some cases it will require an exploratory laparotomy to decide whether one is dealing with the adreno-genital syndrome or polycystic ovaries.

Treatment. In the case of adenoma or carcinoma, the tumor and the adrenal should be removed, being certain, in advance of its removal, that there is an adrenal on the opposite side. If no tumor or hyperplasia is present, the clinician has to decide whether it is in the patient's best interest to remove the adrenals and so exchange Cushing's disease for Addison's disease. Undoubtedly the Cushing's syndrome should be severe indeed to justify such a procedure. The regenerative capacity of the adrenals is so great that to remove only part of one or both is usually to give the patient only partial and temporary relief.

Thirty to forty per cent of patients are said to be relieved, usually temporarily, by heavy doses of irradiation to the pituitary. Unless one is reasonably sure that hyperplasia or tumor is present, it is perhaps in the patient's best interest to use irradiation first. The combined use of pituitary irradiation and unilateral or partial adrenalectomy is said to induce satisfactory remission in over half of the cases.[3]

One might hazard the guess that where evidence points strongly toward the adrenals as the responsible factor, exploratory laparotomy will be used with increasing frequency.

Perhaps we shall some time have a drug that will act on the adrenals much as thiouracil acts in hyperthyroidism. At the present time our nearest approach to such a product is Amphenone,® which is not in clinical use.

If it is decided to remove either or both adrenals, the pre- and post-operative care of the patient sometimes presents difficult problems. Cortisone or some similar preparation will need to be given before, during and for some time after the operation. During, and for some hours after the operation, hydrocortisone will need to be given intravenously. In case of an atrophic contralateral adrenal, ACTH will need to be given for some time postoperatively to stimulate its return to normal function.

CASE REPORTS

Case 1. A 62-year-old woman consulted her physician because of excessive tearing and prominence of her eyes. Her other complaints were: salivation, voracious appetite, excessive hair on the face, and hypertension. Her face, she said, had changed in contour, having become full and round. Her own diagnosis, based on the reading of Dr. Van Dellen's column in the Chicago *Tribune,* was Cushing's syndrome. She had twice suggested this diagnosis and each time had been told there was no evidence of adrenal disorder. The comment was particularly on the absence of acne, cutaneous striae and the "buffalo hump."

She was 5 feet 3 inches in height and weighed 126 pounds. Her face was full and round with excess hair in front of the ears, which were almost obscured by the cheeks. The abdomen was prominent and showed numerous reddish cutaneous striae. Supraclavicular pads were prominent. The eyes were prominent suggesting exophthalmos.

The regitine test was negative and the I^{131} uptake normal. Serum cholesterol was 426 and the BMR minus 27%. The glucose tolerance test showed blood sugars as follows: Fasting 110 mg.%; after 100 grams of glucose, 208, 280, 230, 190 and 95 mg.% at 1, 2, 3, 4 and 5 hour intervals. Glycosuria occurred during the test. There was no evidence of osteoporosis in August 1955, but by November it was well marked.

It was hoped that irradiation of the pituitary would have a beneficial effect. This was carried out in Moline under the supervision of Dr. J. G. Gustafson and Dr. Lewis N. Sears. It brought no relief. As a matter of fact, her progress continued rapidly downward.

A few months later she returned for further study. The flat plate and intravenous pyelogram were reported as normal. The 17-ketosteroids and 11-17-oxysteroids were within normal limits and showed no significant change after intravenous ACTH. At operation a carcinoma and the right adrenal were removed. There was little improvement. Four months later she was rehospitalized because of diabetes—believed due to pancreatic metastasis—and convulsive seizures. She died six months after operation of metastatic cancer of the pancreas.

Case 2. A 16-year-old girl complained of obesity, oligomenorrhea and depression. Despite efforts to diet she had gained 20 pounds in the previous two years. Her periods began at 13 and were regular for one year. After that they had occurred infrequently, the

last one several months before she was first seen. Her school work was not as good as the previous year and social contacts were beginning to be a problem.

The past and family history contributed no helpful data.

She was 5 feet 7 inches in height and weighed 218 pounds. Blood pressure 145/80. Her face was round and ruddy. There was considerable acne in the temporal regions and numerous large purplish striae on the abdomen, breasts and inner aspects of the upper arms. The latter, she was sure, had appeared within the previous 30 days. Supraclavicular fat pads were prominent. The abdomen was large and protuberant, but otherwise negative except for the striae. The cervical dorsal hump was not prominent.

The blood count showed RBC 3,930,000, WBC 7,400, Hb. 77% or 12.5 grams with a differential of 3 eosinophiles, 52 segs, 44 lymphs and 1 mono. The total eosinophil count was 12 mm.[3] The fasting blood sugar was 100 mg.%. After 100 grams of glucose the blood sugars were 200, 200, 125 and 100 mg.% at ½, 1½, 2½ and 3½ hour intervals. There was no glycosuria. The 17-ketosteroids were reported as 17 mg. per 24 hours, pregnanediol 7.5 mg. per 24 hours, total corticoids in the blood 3.02 mg.%. The sella was small. There was no osteoporosis. Perirenal insufflation was thought to show hyperplasia of the left adrenal. Biopsy showed an inactive endometrium.

Three quarters of each normal appearing adrenal was removed. No pathologic diagnosis of the adrenal tissue was reported.

Within 72 hours after the operation the striae on the arms had paled markedly. She rapidly lost weight down to 191 pounds. Her periods became regular. This, however, was assisted by cyclic administration of estrogens. When these were discontinued, she skipped a period. However, the periods reappeared after small doses of irradiation to the pituitary and adrenal regions. Undoubtedly further relief will depend on heavier doses of irradiation to the pituitary, which she is now receiving.

Case 3. A 34-year-old woman complained of menorrhagia, overweight, swelling of the feet and ankles, backache, and shortness of breath.

Her periods began at 10, occurred at 28 to 30 day intervals up to about age 31. At that time she began to skip 1 to 3 months and then would flow 30-35 days. When first seen she had been flowing for 72 days. The periods had ceased for a few months following a D & C six months earlier.

She was thin up to age 11 but plump by 13. There was a rapid gain after marriage at age 21, most marked after a miscarriage in 1950.

She was 5 feet 2 inches in height and weighed 191 pounds. The obesity involved the body and face. Her complexion was ruddy and her face so round and full that, standing directly in front of her, one could hardly see her ears. There were a few pale striae about the iliac crests. Blood pressure 140/100.

BMR was plus 10%. Sedimentation rate 20 mm. Blood count showed RBC 3,900,000, WBC 8,600, Hb. 77%; Segs 82, Lymphs 14 and Monos 4. The glucose tolerance test showed fasting blood sugar 127 mg.%, and 181, 332 and 344 mg.% at ½, 1½ and 2½ hours after the administration of 100 grams of glucose. There was sugar in the urine in the last two specimens. Nonprotein nitrogen 41 mg.%.

Medical treatment was of little avail. In a year she lost only 20 pounds.

The X-ray showed a suspicious shadow above the left kidney. There was no evidence of osteoporosis and the sella was normal. The 17-ketosteroids in the urine were 6.05 mg./24 hr. before and 8.16 mg./24 hr. after ACTH. The total corticoids were 7.85 mg./24 hr. before and 14.55 mg./24 hr. after ACTH.

A cortical adenoma was removed with the left adrenal. She received cortisone and ACTH preoperatively and for about two weeks postoperatively. There was a gradual loss of weight. Eight months after the operation she weighed 142 pounds. Blood pressure 120/80. Her face is now normal color and her glucose tolerance test has returned to normal. Her periods are regular and normal. A postoperative hernia is present.

Case 4. A 34-year-old woman seen in 1934 complained of hypertension, irritability, shortness of breath and precordial distress. She had known of her hypertension for four years. (B.P. 260/145). It was first noted during pregnancy. Her eyes were prominent and the conjunctivae were injected. There was an excessive amount of hair over the face and body. A diagnosis of Graves' disease had been considered but was discarded when the BMR was reported minus 5%. Essential hypertension was considered as the cause of her trouble.

Irradiation of the pituitary and adrenal region was given between September and December 1934. This consisted of small doses of X-ray—50 R to each area treated. The symptoms were relieved and the blood pressure decreased to 195/135.

She was again seen in December 1935. Blood pressure 250/160. The BMR determinations, reported from another hospital, were +35% and +55%. She complained of headache, palpitation, dyspnea and was occasionally disoriented. X-ray treatments gave slight and temporary relief. She died of myocardial failure January 1936.

Postmortem examination showed hypertrophy of the heart, nephritis, hyperplasia of hypophysis and thyroid, and adenomas of both adrenals. The last were so small that they could not have been detected except by exploration. This seems to us to present a strong objection to the use of perirenal or presacral insufflation on the basis that a negative finding may deter the surgeon who might, on exploration, find and remove the offending cortical adenomas.

Case 5. A 51-year-old baggage handler was referred by the Medical Department because of obesity and a story of convulsive seizures, thought to be epileptic. There was no mention of any other episodes although it developed later that he had had paroxysms of hypertension and pheochromocytoma had been suspected and sought for.

He was 5 feet 8 inches in height and weighed 265 pounds. Blood pressure 110/70. The blood count was reported as showing polynuclears 79, hematocrit 53, with a normal number of red and white blood cells.

This is a case of the left hand not knowing what the right was doing. If the paroxysms of hypertension had been known to the endocrinologist, he might have added his mite to the search for some adrenal disorder as a cause of this man's trouble. However, this in no way excuses the endocrinologist for having failed to be alerted by the obesity, the hematocrit reading and the differential blood count.

He died February 24, 1956. Postmortem examination showed hypertensive heart disease and a tumor of the right adrenal cortex. Considering the man's size and the size of the tumor, it seems unlikely that any amount of air insufflation would have been helpful.

Case 6. A girl, aged 17, was seen in January 1956. Her only complaint was of obesity. Her periods began at 12 and occurred at 28-day intervals. There were no significant data in the family or past history.

Height 5 feet 4 inches. Weight 211 pounds. Blood pressure 145/90. Her face was full, round and red. There was some acne about the shoulders and back and purplish striae on the lower abdomen, upper thighs, flanks, breasts and inner aspect of the upper arms. The clitoris was normal size. Rectal examination was normal.

Single eosinophil count 150. Glucose tolerance test normal. 17-ketosteroids in the urine varied from 7.5 mg./24 hr. in January 1955 to 20.3 in December 1955 and 21 in August 1956. (After ACTH intravenously it was 30).

Her weight increased to 225 pounds by August 1956.

The X-ray showed no suspicious shadows either on flat plate or by the intravenous pyelogram, and there was no evidence of demineralization.

Treatment has consisted entirely of dietary restrictions, small doses of thyroid and appetite-depressing drugs. She lost 25 pounds in weight from August to November 1956. Striae have remained stationary. The decision to continue her on medical management was based on the facts that her obesity yielded to dietary restrictions and that her general health is too good to warrant operative procedure.

Case 7. A 15 year old girl, seen in November 1952, complained of obesity, which began following removal of tonsils and adenoids at age 7 but had been particularly rapid in the previous six months.

Hirsutism, which had become marked in the previous six months.

Headache, frequent but not daily.

Amenorrhea, three months' duration.

Her home situation was such that she lived under great emotional strain. She had been under the care of a psychiatrist, who had given her insulin and electric shock therapy with no improvement.

She was 5 feet 3 inches in height and weighed 192 pounds. The obesity was confined to the face and trunk. The cervicodorsal hump was not marked. Blood pressure was 105/75. Her hair was dark and coarse with a male type of escutcheon, with considerable on the chest, back and abdomen. There was a great deal of acne about the face. Her complexion was ruddy. There were marked reddish-purplish striae on the breasts, lower abdomen and upper thighs.

The Illinois Research and Educational Hospital kindly accepted her, and the staff made an exhaustive study of her case. The physical examination was as already noted. The laboratory reports were as follows:

"Urinalysis within normal limits concentrating to 1.035. Hemoglobin 13.2 grams; hematocrit 45, sed. rate 28, WBC 10,500 with normal differential; fasting A.M. eosinophil count 140, repeated 454. Glucose tolerance curve: Fasting 79, 30 min. 107, 1 hr. 101, 2 hr. 83, 3 hr. 86, and 4 hr. 63 mg.%. Insulin tolerance within normal limits. Sodium 144, potassium 4.1 meq./liter. Kepler Power water test normal. . . BMR minus 15%. EKG within normal limits. X-rays on 11-26-52 on skull, spine and chest within normal limits. I.V.P. no abnormalities seen."

She was considered as having no organic endocrine disorder and was followed in the Outpatient Psychiatric Department. She became well adjusted, lost about 50 pounds, and her periods became normal. If there be any truth in the adage that the proof of the pudding is in the eating, the spectacular results of treatment would certainly seem to confirm the diagnosis.

In October 1956 she again came under observation because of a rapid increase in growth of hair on her body and gain in weight, which had begun six months earlier. The blood count showed RBC 4,370,000, WBC 9,200, Hb. 13.05 grams; Eos. 5, Stabs 1, Polys 65, Lymphs 25 and Monos 4. The glucose tolerance test was normal. Reports of the steroid determinations were as follows:

Nov. 12, 1952

17-ketosteroids .... 18.8 mg./24 hr.

About one month later the Illinois Research and Educational Hospital reported:

17-ketosteroids .... 14.2 mg./24 hr.
17-ketosteroids .... 14.6 mg./24 hr.

Oct. 1, 1956

Total Corticoids .. 6.42 mg./24 hr.
17-ketosteroids .... 12.5 mg./24 hr.
Pregnanediol ..... 16.73 mg./24 hr.

After 8-hour intravenous infusion of 25 units of ACTH:

Total corticoids ... 22.6 mg./24 hr.
17-ketosteroids .... 17.5 mg./24 hr.

There was no osteoporosis, and no abnormality could be demonstrated in the adrenal region. It was her wish that the adrenals be explored and this was done, using the abdominal approach. The right ovary was cystic and slightly enlarged. The right adrenal was normal size. The left was about twice normal size. One half the right and two thirds of the left were removed. The left showed adenomatous hyperplasia. No sort of air insufflation would have been of any assistance.

Considering the relation of the hypothalamus to the

emotions and as a possible cause of Cushing's syndrome, one might wonder whether the prolonged and profound emotional strain had something to do with causing the adrenal disorder.

Case 8. A 38-year-old woman awakened one morning in March 1955 with an inflamed vulva and clitoris. This attack subsided in about two days. Similar but more severe attacks occurred near each menstrual period for the next seven months with the exception of June. They were accompanied by hypertension and later by acne, canker sores and soreness about the rectum. During the October attack she was given an injection of cortisone. This gave immediate relief and the November attack was mild. The December attack was of the usual severity.

She had had frequent attacks of migraine since childhood. These disappeared with the onset of the present trouble.

The past and family history supplied no significant data.

Height 5 feet 1 inch. Weight 130 pounds. Blood pressure 150/95. Her face was full, round and semicyanotic in appearance. There was some excess hair in front of the ears and acne scars about the face, chest, back and right shoulder. There were slight supraclavicular pads and dorsal cervical hump. There were very few cutaneous striae. There was considerable tenderness over the right lower quadrant. The physical examination otherwise developed nothing of significance.

The blood count was normal. In February the differential count showed eosinophiles 2, polynuclears 57 and lymphocytes 41. Nine months later it showed eosinophiles 1, polynuclears 77, lymphocytes 20 and mononuclears 2. The glucose tolerance test was normal. The serum calcium was 8.5, phosphorus 3.0 and nonprotein nitrogen 35.5 mg.%. The BMR was normal. The Thorn test showed eosinophil 176 before and 44 after ACTH. The 17-ketosteroids were 5 mg. per 24 hr. X-ray studies of the spine and kidney region were normal.

Meticorten 15 mg. per day gave complete relief and a sense of euphoria not experienced for a long time. However, this was accompanied by weight gain, acne, increased rounding of the face and duskiness of the complexion. The dose could not be adjusted to give relief without these unpleasant side effects. Each period was accompanied by more discomfort.

The abdomen was opened in the belief that we were dealing with adrenal hyperplasia or tumor, the Stein-Levinthal syndrome, or endometrosis. The right adrenal was so small as to be barely palpable, the left about three times normal size and containing numerous nodules. The entire left adrenal was removed, and a cyst from the left ovary.

Within four days her face had lost its dusky color and all signs of acne except the scars had disappeared. She was given cortisone intramuscularly in decreasing doses for three days, then Meticorten by mouth in decreasing doses. The last was given on the seventh postoperative day. ACTH 20 units intramuscularly was given alternate days for three doses.

It is too early to know whether this will completely relieve her trouble. However, the fact that symptoms could be relieved by Meticorten and recurred when it was stopped and that the right adrenal was atrophic and the left enlarged and filled with adenomata give some basis for hope that the cause of her symptoms has been removed.

SUMMARY

The ultimate cause of Cushing's syndrome is an overproduction of 11-17-oxygenated steroids of the adrenal cortex. A basophil adenoma of the anterior pituitary seems responsible in some cases, the hypothalamus in others, and in still others some disturbance of the adrenal itself seems to be at fault. The disease is probably not as rare as is generally thought. If physicians would remember that fat women whose obesity is largely confined to the face and trunk and who have some excess hair and/or cutaneous striae are possible victims of Cushing's disease, probably a great more cases would be recognized and treated. Cases representing various aspects of the disorder are presented.

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Highway Safety

Governor William G. Stratton

THE honor of talking to you tonight is coupled with the special privilege of being able to discuss with you a problem that has aroused our mutual interest, the highly important matter of traffic safety.

As many of you know, I presented to a joint session of the Illinois General Assembly today, at noon, a program looking toward making our highways and streets safer, and toward curbing the reckless and speeding motorist who endangers our lives.

I am very hopeful that the legislature will enact that program into law, for I know the intense interest the members of the General Assembly, and the public have in this matter.

It is doubly encouraging, too, that the Illinois State Medical Society has designated medicine and traffic safety as one of its major projects for this year. The year 1957 can well be a year of great progress toward ending the highway butchery.

Behind this program of our state administration are the same elements — the saving of life and the prevention of suffering — to which you have dedicated your lives. It is indeed a sad commentary that with the great strides medical science has made in its war on disease, we must risk the lives you save on highways that should be avenues of commerce and pleasure, but too often are avenues of death and suffering.

The horrible effects of impact on the human body will be dramatically presented to you in a very few minutes by Dr. Fletcher D. Woodward. He, in a scientific manner, has assessed the multiplying factor of speed in accidents, a factor which we also have considered in our request for definite and enforced speed limits. I am certain that after you have heard Dr. Woodward, you will agree that speed compounds the damage



Governor William G. Stratton

which can come from an automobile badly handled, recklessly driven, or inconsiderately directed.

It is most gratifying that medical science is tackling this problem too, and we in government welcome the help.

In a sense the problem of traffic safety can be attacked much as a health problem. Here we have the phenomenon of the American people killing themselves on their own highways. Like public health, this problem of public safety is a problem for all of us, to be considered at all levels of governmental and public activity.

Long ago we collaborated, we in government and you in the medical profession, to put this state in the forefront of the war to prevent dis-

Presented at Legislative Dinner of Illinois State Medical Society, Springfield, Illinois, March 12, 1957.

ease and promote health. The health, welfare and safety of our citizens is a basic concept of our government.

Now, in this case we have a disease, if you please, which is killing an average of six persons each day in Illinois. It must be brought under control.

Disease at times calls for a quarantine. It would be unthinkable in the case of public health to fight disease without adequate law to help the medical profession control and eradicate the disease and its causes.

So in traffic safety we must have a kind of quarantine. We must have laws with teeth in them and we must enforce those laws. That is the purpose of the message I delivered today to the General Assmbly.

There is another parallel we can draw here. That is the matter of education. No factor in public health administration is more important than the education of the public in their responsibilities and duties. Through education, with concurrent work of your profession and the marvelous discoveries of your technicians and doctors, there has been a steady decline in death rates from communicable disease and a constant increase in life expectancy. From the time a child is born the lessons of the past, distributed through educational measures, begin to give that child a better chance for life than at any time in the history of our world. Cleanliness, infant care, vaccination, the miracle of the polio program, the care of teeth, posture, all of these factors are brought to the child's advantage through education.

How comparable our traffic situation is. Better engineering, both on the roads and in our cars, are the contributions of science in this fight. Our laws can provide the quarantine, but we must also educate for safe driving, train in proper driving attitudes.

As I said today the high school driver training program appears to be an extremely important approach. Not all the high school students are going to be doctors, or stenographers, or farmers, or carpenters.

But all, or virtually all, will drive cars.

To the end of providing this education I have asked the Legislature to make a beginning this session by raising driver license fees for the purpose of some form of state aid to driver education in the high schools.

I am certain that one section of today's traffic safety message will be of special interest to this group. I would like to quote here for a moment:

"None of us has doubt there are some drivers who are either physically or mentally unequipped to drive an automobile on our public highways.

"There are laws now that should prevent such persons from driving. I speak of those afflicted by some disability which might endanger the safety of the general public. The problem is to find such persons. Our driver license examination can not in itself search out all such persons — persons for example who are normal in all outward appearance, but might be subject to instability or seizure at a time when such a seizure would contribute to accident and death.

"I recommend, then, that later in this session, after a study now underway has progressed, this General Assembly pass a law to require reports by physicians who in the conduct of their profession discover physical or mental disabilities which would render their patients potentially dangerous drivers.

"This, I am certain, can be done with no infringement on the high ethics of the medical profession. In fact, encouraging meetings have been held toward this goal with representatives of the leading professional societies of the state."

I received in my office today some new figures, representing the findings by the psychiatric institute in Chicago, on referrals to that institute by the traffic courts of Chicago.

It is important to bear in mind here that the referral system being tested is very rigid, with consequently a small sampling of what might be expected.

In the period between February 1, 1956 and December 31, 1956 there were 51 referrals. One of these was found to be suffering from brain tumor, and he died in a very few days in the house of correction hospital.

That is one example of the close correlation between medical skills and traffic safety.

There were nine persons found to be suffering from mental illness. Three were determined to be mentally deficient. Nine had severe neurosis, ten suffered from personality disorders, and two were found to be senile.

And here is an important discovery. Of the 51 persons, three were suffering from epilepsy, one had major paralysis due to a stroke, five were chronic alcoholics, one was subject to diabetic coma, and so on.

All this from 51 cases referred. Is it any wonder that we believe that here is a field in which we can work together in the closest cooperation. I urge your careful analysis of this problem with me, and I ask that your studies in this regard be expedited. Remember, this is a disease, this reckless, hazardous, death dealing traffic situation.

We must fight it now on all fronts, in all fields of endeavor. I am certain I can plan on your help, both as professional men, and as citizens who by your positions enjoy places of community leadership.

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Crash belts

Many fatalities occur in relatively minor accidents because motor car doors fly open at the least impact and occupants are killed by being thrown from the car whereas those who stay in the car are hurt very little. Latches on modern car doors differ slightly from latches on carriage doors of 50 years ago. One of the axioms of package engineering is that the container must remain intact. It is impossible to transport fragile china or delicate and expensive machinery if the package opens and spills the contents. Nowhere does this principle apply with such force as in the motor car. It has been known for years that the motor car door which, even in 1955 cars, pops open all too easily, was the cause of much morbidity and mortality. All the stock car racers that I have seen strap or wire the doors of even the most recent models. These gentlemen are not convinced by the manufacturers' claims that the door of late model cars do not pop open. *Horace E. Campbell, M.D. We Can Prevent Injuries in Automobile Crashes. Rocky Mountain M.J. Sept.* 1956.

Migraine and hostility

Not all patients with migraine are compulsive, perfectionistic, or rigid. A recent objective psychologic evaluation of our patients confirms this point of view. In this investigation, psychologic test data were analyzed for 100 patients with migraine and tension headache. Repressed hostility is an extremely common factor among many persons who do not have migraine but may have hypertension, ulcers, or just a small bank account. In fact, some of the patients who develop migraine during the course of their therapy or following relief of their symptoms from headache may develop and have developed duodenal ulcer, arthritis, colitis, vaginal spasms, and depression. An understanding of the underlying psychologic factors plays an important part in the management of migraine, for in the ability of the patient to handle emotional tension lies the most satisfactory means of preventing the attacks in the majority of cases. *Arnold P. Friedman, M.D. The Psychologic Aspects of Headache Therapy. New York J. Med. Aug.* 1, 1956.

Accidents Will Happen

Fletcher D. Woodward, M.D., Charlottesville, Va.

THE old saying that accidents will happen is partieularly true when applied to automobiles and sincc aeeidents produce deaths and injuries, we must accept a certain basic number as inevitable in our eomplex and mobile society. But this number can be reduced to approximately one-third or less of our present appalling number if we are willing to apply the remedies we now have.

The magnitude of this problem, is indicated by the faet that there is one death (and twenty-five injuries) every ten minutes from an accident rate of one every three seeonds. In all our wars, less than one million men have been killed. The automobile eounted its one millionth victim four years ago and the rate has been aceelerating since, with increased horsepower.

In 1955 the passenger death rate per 100 million miles for air transportation was 0.76, for the automobile 2.7 — or 3½ times as great. For Virginia it was 6.6, or 8.7 times as great. For Virginia, in 1954 the percentage of fatal accidents in which a drinking driver was involved was 25.8% and for those in which speed was a factor, it was 33%.

To further impress you with other aspects of this problem, the Allstate Insurance Company, one of the nations largest, reported its profits at less than $100,000 for the first half of 1956. Their profits were $10,500,000 in a similar period in 1955. The State Farm Mutual reported its injury claims up 13% for the first half of 1956. Automobile liability rates were recently raised in New York, Pennsylvania and Rhode Island and no doubt many other states will be forced to do likewise. The Institute of Life Insuranee says highway accidents in the past four years eost the life insurance companies more than did World War II.



Fletcher D. Woodward, M.D., addressing the Legislative Dinner at Springfield.

Cardiovascular diseases and eancer are our two leading causes of death but the automobile rate is close behind if figured on many years of life lost, for the first two are primarily diseases of the older age groups whereas the automobile fatality rate is highest in our younger age group.

In 1925 there were 20 million automobiles and a death rate of 19 per 100 million miles. In 1955 there were 60 million automobiles but the death rate had been redueed to 6.4, a most gratifying improvement, whieh figure is now approximately static, for otherwise the deaths last year would have been over 100,000 instead of 40,000. The credit for this result is due to the automobile manufaeturers, the poliee and the many national, state and local safety organizations whose

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indefatigable work over the years made this improvement possible.

However, the fact that concerns the doctors who are called upon to pronounce death or treat these unfortunate victims night and day is that there is also a slow but steady increase in the total number of deaths and injuries each year. In 1946, there were 34,000 deaths; in 1954, 36,000; in 1955, 38,000, and in 1956 — 40,000. This year, 42,000 are expected. These deaths were associated with a comparable increase in injuries which last year numbered well over one and one-quarter million. If this trend is continued, the National Safety Council estimates that in 1966 there will be 53,000 deaths from 83 million cars and a corresponding increase in injuries.

In a search for the causes of this tragic toll each year, three factors stand out above all the rest — speed, drunken driving and poorly designed automobiles from a safety standpoint. The remedy, though complex, concerns itself with (1) prevention of crashes and (2) prevention of death and injury. To this end, let's first examine speed and drunken driving since they are associated so intimately.

Speed: There are many people who still maintain that speed is not a main factor in automobile crashes but last year in Virginia 40% of all such crashes involved but one car which made no contact with another and the speed limits were violated in 39.2% of our fatal rural crashes. Last December Governor A. B. Ribicoff of Connecticut ordered that drivers' licenses, without exception, be suspended for 30 days on a first conviction for speeding, 60 days on the second and, at the end of the first 6 months, a 14% drop in highway fatalities was noted. Governor Langlie of Washington found a similar happy result when they applied their tough but courteous policy. Speed is a frequent contributing factor also in such violations as drunken and reckless driving and driving on the wrong side of the road.

While most fatal accidents occur in the 30-50 mile an hour speed range and 30% occur under 30 miles per hour, many other factors enter here, notably automobile design. The average steering wheel collapses at 12 miles per hour on impact, leaving the steering post as a lethal projection. No passenger is able to protect himself from injurious impact in the average car at speeds greater than approximately 12 miles per hour.

It is a pity that speed and acceleration are so emphasized in advertising. It is admitted that modern motors are more efficient and economical. But the 12 year old mentality who buys the cars so advertised cannot help but try them out on the road and so becomes another casualty.

The speed factor can be curtailed but only by education of the public, the legislator and the traffic court judge, for the public must demand adequate laws. The legislator who follows the public's wishes will then provide the laws — laws far more stringent than any that now exist. The traffic court judge must administer these laws with courage and impartiality.

The Drinking Driver: The next most important factor in curtailing death and injury on the highway is to curtail the drinking driver who caused one-fourth of our fatal crashes.

Again, the remedy lies in education of the public, the legislator and the traffic court judge. Our laws must provide for a chemical test to determine drunkeness in suspected individuals. This test must be mandatory and an alcohol blood level of 0.15% must be accepted as evidence of drunkeness. Also, adequate punishment must be provided for the still bigger problem of the drinking driver whose alcohol blood level falls into the twilight zone of .05 to 0.15%. A mandatory jail sentence must be provided and again the traffic court judge must administer the law with courage and impartiality. The day of suspended sentences should cease.

The only redeeming feature in these two problems that exists today is the high quality of work being done by our police officers. However, their zeal is bound to suffer when they are constantly faced with the apathy of the public, the legislator and the traffic court judge.

Automobile Design: As a result of slow but methodical compilation of statistics by individual physicians, universities and by public and governmental agencies, it has been shown that redesign of the machine itself is important and that many deaths and injuries can be prevented.

While much more research is needed, there is no reason why we should not employ the facts we have which are sufficient at this time to prevent some 50% or more of the deaths and in-

juries by desgining a machine to fit and protect the human from. Many of the manufacturers, led by Ford, are studying this problem and installing safety devices on their cars. If such a program could be made competitive by public demand instead of size, horsepower, acceleration and speed, then the day would soon dawn when the death and injury rate would start subsiding.

Among the suggestions offered to improve safety are safety belts and body harnesses, crash padding on the dash, ejectable windshields, collapsible steering wheel assemblies, safety locks on doors, the eradication of projecting knobs and buttons, firm anchorage of seats, higher backs to prevent whiplash neck injury, polarized headlights (and, oppositely, polarized windshields), glare-proof paint and shock absorbers. If medicine had waited until all facts were known and available before starting its war on bubonic plague, smallpox, malaria, typhoid, and poliomyelitis, as examples, the conquest of those killers would have been long delayed.

The automotive industry should clean its own house, otherwise a Federal agency will be set up to establish and require all manufacturers to meet certain minimum safety requirements. Several bills to this end have been introduced in Congress and there is a Committee at this time conducting its own investigation. In addition to the Bills in Congress, many state legislatures are considering similar legislation.

The medical profession, although not self-satisfied with its present day accomplishments in the care of the injured, is highly gratified with its results. But, the physician must also study the medical aspects of automobile crashes in an effort to prevent them and further reduce these increasing injuries.

New York University-Bellevue Medical Center and the American Medical Association have made the initial steps this past year to determine driver fitness and to outline the basic requirements of those who wish to drive private cars, taxis, buses and commercial vehicles. They plan to prepare a booklet to serve as a guide to police officers in granting driving permits for each of the three classes.

They also feel that referral traffic court clinics should be set up similar to the Recorder's Court Clinic in Detroit. Since this clinic is to be staffed with trained physicians and psychologists, they hope to prepare a more comprehensive booklet to sreve as a guide to the clinic physicians who will be called upon to examine repeat offenders, those over sixty-five years of age at their tri-annual permit renewal, those referred by the traffic court judge, the police or other physicians.

This booklet would cover a review and recommendation in regard to visual, hearing and physical requirements, the problem of Meniere's disease, petit and Grand mal, as well as other diseases of the nervous, cardiovascular and musculo-skeletal systems, physical conditions, drugs, insulin shock, alcohol and psychopathic personalities.

To lighten the work load of the courts and clinics, there should be more approved public and private driving schools. All prospective drivers should present a certificate of ability when applying and all whose driver permits have been suspended or revoked should present such a certificate before renewal is considered.

I would also like to suggest that the American Bar Association provide some type of uniform instructions for traffic court judges and that the driver's physical fitness be reviewed by the police upon the tri-annual permit renewal for to drive an automobile today is a privilege and not a right.

A large percentage of accidents happen to a small percentage of drivers. This small group of around 10% is composed of a rather constant but nebulous core of drivers called the accident-prone group, the scoff-laws, the lunatic fringe and many other terms less complimentary. Doctor Morris Schulzinger concludes from his exhaustive study that the young maladjusted male with unbridled agressiveness is the chief offender but we also find the alcoholic, the egocentric and, according to Dr. Alan Canty of the Detroit Recorder's Court, the group also contains the individual who has poor control over his emotions, domestic and other social situations. He lacks economic stability, he is unstable, impulsive, irresponsible and insecure. In other words, he drives as he lives, as has been so aptly stated by Dr. Ross McFarland.

This nebulous group is the one that needs the most research study. However, this is not being neglected.

The problem of safety on the highways is so

vast that I have proposed a national foundation for the study and prevention of crash injuries and deaths. The purpose of this non-profit organization would be to receive money, and grants, from individuals, charitable foundations, governmental services, automobile and allied companies, insurance companies and others. These funds would be utilized to stimulate and guide research in needed channels and to prevent duplication. It would also serve as a central repository or library.

It is obvious that much more research is needed, but we have enough facts now to curtail our injuries and deaths fifty or more per cent if followed. To accomplish this goal, I propose further study of the four E's:

(1) *EDUCATION*: Accredited driver education schools should be established in private, parochial and public high schools. There should also be accredited driver schools for the public.

All applicants for driver licensure should be required to present a certificate from such a school. The same certificate should also be required from those who are reapplying for driver licensure after suspension or revocation of their licenses.

Referral clinics staffed by physicians and psychologists should also be established. It would be their duty to pass on the fitness to drive of repeat offenders, those referred to it by the police, the court, the physician and those past 65 years of age at the time of their triannual examination. Such a referral clinic could be similar to the clinic which has worked so well for the Recorder's Court in Detroit.

(2) *ENACTMENT*: By education of the public and the legislator, adequate laws can be enacted to adequately punish the drinking and speeding driver — laws far more stringent than any which now exist on our statute books. These laws need to provide higher fines and longer periods of permit revocation or suspension; mandatory jail sentences for the drinking driver with a minimum of at least one day in jail; mandatory drunkometer tests of suspected individuals, and the acceptance of the results of such tests as evidence of drunkeness. Last of all, suspension of longer sentences should be sharply curtailed.

(3) *ENFORCEMENT*: More highway police officers are needed and the American Bar Association should educate the traffic court judges and juries to back them up. If the judge and jury could see the dead and mangled bodies seen by the police and the physicians, they would quickly meet this suggestion.

(4) *ENGINEERING*: In addition to the vast amount of engineering now going into the design of our highways, I would like to see safer automobiles provided which would protect us in those accidents which seem to be inevitable. These features have been repeatedly ennumerated by physicians and repeatedly ignored by designers and engineers of automobiles.

From the purely medical aspects, the American Medical Association is currently engaged in a study of the effects of disease on driving skill and in the publication of a comprehensive book on this subject to guide the physicians and psychologists working in the driver referral clinics, a less comprehensive book for the education of the general physician and a still simpler one to guide the examining police officers in conducting their examinations for driver licensure in each of the three recommended categories: (1) private vehicles, (2) commercial vehicles, and (3) those for public transportation as taxis and buses.

If permits are so issued, then the permit for private transportation can be revoked for due cause and the other left in force when necessary for the earning of a livelihood.

400 Locust Avenue

Medical Education in Illinois: Beginnings, Obstacles, Encouragement, Dreams

Joseph H. Kiefer, M.D.,
Associate Professor of Surgery and Head of the Division of Urology

Lester S. King, M.D.,
Clinical Associate Professor of Pathology

Josiah J. Moore, M.D., Moderator

Frederick Stenn, M.D.,
Assistant Professor of Medicine
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Doctor Samter: The patron saints of today's Seminar look at us from the walls of this room. Unfortunately, many of us not only fail to recognize the pioneers of medicine in Illinois, but also to appreciate who and what brought us to where we are today. We are fortunate to welcome a panel of historians - Doctor Lester S. King, Doctor Joseph H. Kiefer and Doctor Frederick Stenn. Doctor Josiah J. Moore, who is, indeed, part of the history of medicine in Chicago, has kindly agreed to serve as moderator of the symposium.

Doctor Moore: Thank you Doctor Samter. Actually, I had counted on talking at the end rather than on moderating this distinguished panel, so I shall ask Doctor King to bring us up to date on medical education prior to the founding of the University of Illinois College of Medicine.

Doctor King: In briefly presenting what preceded our school, I must return to 17th century England where medical education consisted of fourteen years at Oxford or Cambridge. Four years of study of the classics led to the Bachelor of Arts Degree. Three years of work in the natural philosophies — physics, chemistry, etc., — earned a Master of Arts Degree. The candidate then studied three years to become a Bachelor of Medicine and a final four years for his coveted M.D. We must wonder what these men found to study so long and, in fact, many physicians of the time despised the curriculum. London law, however, required an M. D. degree for the practice of medicine. The course of study was costly and there were only a few doctors who had, in effect, a monopoly.

There was a totally different form of medical education by the apprentice system. These practitioners were the surgeons and the apothecaries, who learned by on-the-job training without any formal education. The learned physicians with long training were few in number and charged high fees. There were not enough to go around, and most of the medical work was done by surgeons and apothecaries. The latter started out merely filling the prescriptions which the physicians wrote, but soon were prescribing themselves. There were very bitter struggles between the few highly educated physicians and the many practically-trained apothecaries.

In the latter 18th century, the educational system changed, making it possible for the apothecaries to get a sound medical training, much more practical than the universities offered. Hospitals were founded, giving an opportunity for bedside teaching. Private dissecting

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Associate Professor of Medicine

academies made it possible to learn anatomy at first hand. Private lecture courses were given in chemistry, botany and materia medica. The lecturers earned fees only when the lectures were popular. Perhaps this might be applied to our teaching today. Also new medical schools were founded, the most famous of which was Edinburgh where excellent training might be obtained.

The Edinburgh system was transplanted to this country in 1765 when the first medical school in America was founded at the University of Pennsylvania. In the eastern section of the United States there were relatively high standards, but the development of the middle west was accompanied by very low medical standards, on a par with 17th century apprentice training in England. Steps were gradually taken to improve the situation. Proprietary medical schools of inferior quality arose in the middle 19th century. One example was the Long Island Medical School in Rock Island. One single course of 16 weeks covered all the medical curriculum and was sufficient to turn out a doctor at that time in Illinois. Thus began medical education in Illinois, and Doctor Kiefer will discuss the further development.

Doctor Kiefer: The first medical school in our state was opened by a Doctor Franken at St. Charles in 1842. His ill-fated venture collapsed when one of his 12 students was shot and killed by a citizenry aroused over grave robbing. The following year, Rush Medical College opened its doors in Chicago and Illinois College of Jacksonville created its own medical school. The latter lasted only a few years, but Rush continued until its affiliation with the University of Illinois in 1942.

Rush was a proprietary school and presented lecture courses which were repeated annually. The student graduated after exposure to the same lectures for two or three years. Not until 1880 was a graded curriculum introduced there.

In 1859, a group of rebels from Rush organized a medical school with a graded curriculum: this affiliated with Lind University (now Lake Forest College). While three years of study were recommended, graduation was possible after two years. In 1866 this school became the Chicago College of Medicine and in 1891 became Northwestern University College of Medicine.

Other schools formed in Chicago during this period were The Women's Medical College, Hahnemann School of Homeopathy, and the Bennett College of Eclectic Medicine and Surgery. The latter taught *all* systems of healing—leaving to its graduates the choice of methods to be used. This school remained open until absorbed into the Loyola University Medical School about 1913.

The College of Physicians and Surgeons (P. & S.) was organized in 1876 by C. W. Earle, A. Reeves Jackson, D. A. K. Steele, Mr. S. A. McWilliams, and Leonard St. John. Cook County Hospital had been erected at its present site and Rush Medical College had been rebuilt after a fire in 1871. The five men formed a stock company and any man who purchased $2,000 in stock had sole right of lectureship in the field of his choosing. The corporation erected a building directly opposite Cook County Hospital and opened in October 1882, with 165 students. The faculty consisted of able and dedicated practitioners. It was far above average for its time. If the class size seems large, we must mention that in 1882 Rush had 552 students and graduated 183.

The school got students but lost money. The company was reorganized because of debts in 1892. Bayard Holmes rejuvenated the curriculum and a laboratory building was erected next to the school. P. & S. was the first private medical school in the country with teaching laboratories, with Rush following close on its heels. William E. Quine was named president and the school prospered. The State of Illinois became interested and Governor Altgeld made overtures toward purchase of the school in 1896. For 17 years, P. & S. functioned under the lease to the state with repeated political blocking of its purchase by the state. Classes became larger with over 200 men graduated one year.

As the school prospered, West Side Hospital was built in 1896. (This building, now Cook County's Fantus Clinic is the only P. & S. structure still standing.) Here, clinics were held and the students learned their bedside technique. The West Division High School was purchased and became the medical school building while the original structure became the University's Dental School.

When, in 1907, the Governor unexpectedly refused to sign a bill for the purchase of the school, the corporation asked to withdraw from the affiliation with the University and in 1912 renounced its connection; with the intention of opening again as a private school.

A committee of the alumni of the School now set out to obtain all the company's stock, most of which was given as a gift, though some was purchased by subscription. April, 1913, the alumni committee presented the deed to the P. & S. as a gift to the University of Illinois. Quine was reappointed Dean and the legislature now, for the first time, appropriated funds for operation of the school. In 1919, the Department of Public Welfare appropriated the money which purchased Chicago Cubs ball park where our institution now stands.

Doctor Stenn: So we see that this empire about us was built not by money or by idle dreams, but by the enthusiasm of dedicated men and women who worked unceasingly to improve medical education. I would like, then, to talk about men, particularly about the two physicians who have contributed more than the rest to our growth: Charles W. Earle who made the dream possible, and Christian Fenger who put us on the medical map of the world.

Charles W. Earle of Vermont, the real founder of P. & S. tried to enlist in the Union forces during the Civil War when only 16. He was refused and returned to his new home in Wisconsin where after much persuasion, the Governor allowed him to be drummer at local drills. He excelled and was soon on duty at the battle of Chickamauga in Tennessee. General Steadman ordered the 96th Illinois Regiment to hold its position and retreat under no circumstances. The battle went badly for the Union and the entire Regiment was surrounded and captured. At the prison camp in Richmond, Virginia, Earle and a group of officers dug a tunnel 110 feet long and escaped under cover of darkness. Earle made his way back to the Union forces and fought to the end of the war.

Out of the Army and now a doctor, Earle joined the Chicago Medical College where he served until 1876 when he determined to set up a new school — Old P. & S. He was Professor of Obstetrics at P. & S. and Professor of Pediatrics at the Women's Medical College. His slogan which aptly characterized his spirit of leadership in both peace and war was "Come on, fellows!"

The greatest name in Chicago Medicine now appeared on the scene. Christian Fenger, a graduate of the University of Copenhagen, trained in Pathology under Rokitansky in Vienna and then journeyed to Cairo where his work and study continued. A United States Army officer's wife urged him to come to Bloomington, Illinois, and believing ours was the nation of greatest opportunity, he came to America. In Chicago, he was enticed to stop, but found no golden street paved for him. He found it difficult to earn a living and, by his own account, was given the position of Pathologist at Cook County Hospital only after paying a politician one-thousand dollars.

Fenger was a great teacher who inspired all those in contact with him. He spoke eleven languages fluently, but in a garbled, barely audible manner which perhaps added to his impact on students. And of his thousands of students, we must mention names such as J. B. Herrick, Ludwig Hektoen, A. L. Ochsner, J. B. Murphy, William Black, Charlie and Will Mayo and J. W. Hertzler. Despite the multitude of worshipers gathered about him, Fenger never was intimate with any associate. He was aloof and dedicated.

One night in 1878, a Doctor Moorhead was called to see a patient with fever at 63rd and Halsted Streets. Baffled, he sent for Christian Fenger. Fenger examined the patient, found a severely infected bunion, and correctly diagnosed subacute bacterial endocarditis — the first time the diagnosis had been made in Chicago. Fenger's works are now incorporated in two volumes and represent a real monument to this great man. It was he who established the spirit of pathology in Chicago.

Fenger's favorite student was Ludwig Hektoen, a laboratory man. He was entirely different from Fenger. He left behind some invaluable contributions. To Hektoen, we owe the concept and technique of crossmatching blood for transfusion. He organized and directed the Hektoen Institute at Cook County which began as the McCormick Institute of Infectious Diseases for the study of Scarlet Fever. It was here that the Doctors Dick discovered the streptococcal etiology of scarlet fever, and the now famous Dick test.

Hektoen's primary accomplishment was, in his own mind, his influence upon his students. With this, we must concur; and we must add that through his students, this influence was felt far and wide.

Unfortunately, I see that our time is nearly gone, but I cannot close without mentioning Dr. William E. Quine. Doctor Quine was an ideal practitioner of medicine, of high principles and of a truly altruistic spirit. His impact on Chicago medicine was profound, and his name on your library should be a continuing inspiration. *Doctor Moore*: This stirring history of the beginnings of your great school once again calls attention to the fact that basically our world doesn't change much. This gathering today reminds me of the monthly meetings of our Research Society at P. & S. Those of us who were at the time doing research would present papers before the group. Invariably, each meeting ended with the unanimous admonition that another year or two of deeper research should be done before a paper be submitted for publication. The problems on which we worked fifty years ago, would seem insignificant to you but they were, for their era, as timely as the atomic bomb. As a student, I assisted Doctor Ricketts in his research on Rocky Mountain Fever as the "cowboy of the wood ticks", and I also spent a great deal of time in the field laboratory in Montana.

The dreams of today are the realities of tomorrow. This wonderful hospital in which we meet today is the realization of the "new hospital" we were promised fifty years ago. Yet, there were untold dreams which never came true. When Rush Medical College closed its doors, there were many who dreamed of its conversion to the finest postgraduate medical school in the country; alas, reality dictated far more financial support than was available to accomplish this. Again, for two years a group of us discussed the union of all the medical schools in Chicago to allow the student more freedom of choice. In the arrangement which we had planned, each student could elect to take any given course at the school which best fitted his needs: this, too, never occurred.

The European who arrives in this country is invariably surprised by the lack of freedom in our system of medical education. Perhaps, we should discard our arbitrary standards for admission to medical school, allow anyone who desires to matriculate, and weed out the unfit and unsuited as they become apparent.

There are a multitude of dreams being dreamed and to be dreamed in the future. As progress continues your generation's knowledge, too, will become archaic. We have by no means written the closing chapter of the history of your University, but I think that we all should be proud of the introduction.

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The Chinese call it face

Morale in the Navy is made up of a lot of things but actually, they can be grouped under two heads. When a man's morale is low, he is either not getting enough money or is not being accorded enough dignity. The lack of money is up to Congress and out of our hands, but the lack of dignity covers a multitude of little things, about which we can do a great deal. No man can maintain high morale if he loses his self-respect. Self-respect goes hand in hand with dignity; the two are almost synonymous. The Chinese call it face. When a Chinaman loses face he becomes very unhappy indeed and the same thing goes for the jack-o-the-dust and the captain of the head. Dignity is a comparative thing and what would be a dignified procedure for a boat keeper would not be at all dignified for the Chief Bos'n's mate and would be entirely out of line for the Captain. *Matt-Hensley. The Whipping Boy. U. S. Nav. Inst. Proc. Nov.* 1956.

Clinical Aspects of the Cranial Neuralgias

ROLAND P. MACKAY, M.D., CHICAGO

THE term neuralgia often is misused in general speech to indicate any type of vague and otherwise unexplained pain. Specifically, however, neuralgic pain has certain characteristics that stamp it as unique and are identified in all pain properly called neuralgic.

Neuralgic pain is paroxysmal or lancinating, knife-like or burning, and severe, resembling that experienced when a dentist's drill touches a "live nerve." Pain may be a single flash or may be rapidly repetitive and so may be said to quiver. The acute phase may be followed by a sort of afterglow of diminishing discomfort. Such paroxysms may be associated with secondary motor phenomena such as grimacing of the face if pain is in that area. In addition, the part involved may be immobilized during and even between the attacks, and the victim may throw his hand toward the part involved as if to seize the seat of the pain, but will usually stop short of actually touching the involved area.

This paroxysmal quality is invariably present in neuralgia and two rhythms may be recognized. The first, or short cycle, is characterized by spasms of lancinating pain lasting a few seconds to a minute, followed by the afterglow as described above. These paroxysms of such short duration recur at intervals of a few minutes to an hour or more but in an irregular sequence. Finally, paroxysms may occur spontaneously or from irritation of a so-called trigger zone. Irritation may arise from touch, a movement of the part, even the blowing of air across the area, and apparently excesses of emotion such as fear or apprehension may induce pain. The trigger zone is the most characteristic feature of neuralgia.

The second rhythm consists of a longer cycle in which paroxysms occur in bouts lasting for hours or days and return after periods of freedom lasting days, months, or years. During the intervening normal periods, victims of neuralgia usually are quite free of this type of pain. The precipitants of recurrent bouts are not known. A final characteristic of neuralgic pain is that it may be relieved by anesthetization of the trigger zone. This fact offers an important therapeutic lead.

Presented before Section on Eye, Ear, Nose and Throat, 116th Annual meeting of Illinois State Medical Society, Chicago, May, 1956.

TRIGEMINAL NEURALGIA

The best known of all the cranial neuralgias is that involving the fifth cranial nerve. In these cases, pain is nearly always distributed unilaterally, although cases are known in which bouts occur on one side of the face at one time, and on the other side at other times. Pain usually is restricted to the areas of distribution of one or more of the primary divisions of the trigeminal nerve: ophthalmic, maxillary, or mandibular. Often only a smaller, subordinate branch of a larger division may be affected. Pain, therefore, may occur in one side of the tongue, in the gum, the palate, the cheek (either inside or outside), the lip, or the eyelid. It frequently seems to the patient to arise from a tooth so that mistaken extractions are common.

Symptomatic facial pains may resemble trigeminal neuralgia. For example, pain of this type may be encountered in multiple sclerosis when a plaque of that disease is located in the pons adjacent to the entry of the trigeminal nerve. In addition, something simulating trigeminal neuralgia may result from local disease of the root or ganglion of the fifth nerve: such diseases are aneurysm, primary or metastatic tumor of the Gasserian ganglion, and especially herpes zoster. Occasionally, neurosyphilis causes lancinating facial pains resembling neuralgia. In all these cases, such symptomatic pains may be distinguished from trigeminal neuralgia by finding other evidences of neurological disease such as sensory impairment in the area involved,

weakness of the motor part of the fifth nerve, or signs of multiple sclerosis or syphilis. In herpes zoster, a rash appearing within a few days of the pain gives the diagnostic clew.

Treatment of trigeminal neuralgia is based upon the fact that anesthetization of the trigger zone will give relief. Trichlorethylene by inhalation is a time-honored remedy, but unfortunately usually is ineffectual. A recently introduced drug, Stilbamidine® is so toxic and dangerous to other nerves as well as the fifth, that it has been withdrawn from the market. Injections of branches of the fifth nerve to anesthetize the trigger zone usually are effective and involve attack of the submental, infraorbital, or supraorbital twigs where they make their exit to the surface of the face. Such injections should be made with a local anesthetic and when this substance produces anesthesia of the area, it should be followed by alcohol without withdrawing the needle. A former practice of deep injection of the Gasserian ganglion with alcohol has been abandoned in this country as too dangerous and uncertain. Surgical section of all or part of the root of the fifth nerve is the standard and by all odds the most effective treatment. Such section must spare the motor root and, if possible, attack only the portion of the root corresponding to the area of involvement. Another operation, tractotomy, involves a section on the lateral aspect of the medulla which cuts through the descending root of the fifth nerve, producing analgesia of the face but not anesthesia. Most recently Taarnoj has decompressed the root of the fifth nerve where it passes over the petrous ridge, and this operation is at present being vigorously exploited in many centers with varying degrees of success. Pain, although relieved in the beginning by this procedure, often recurs. In treating patients with trigeminal neuralgia, anesthetization by injection on two or three occasions should always precede surgery in order to familiarize the patient with the discomforts of the anesthesia lest, having been relieved of his pain and having forgotten its severity, he consider himself more unfortunate in having a numb face than he formerly was in having the pain.

GLOSSOPHARYNGEAL NEURALGIA

Glossopharyngeal neuralgia resembles trigeminal neuralgia in all respects except that pain is distributed to the lateral area of the pharynx, the soft palate, and the base of the tongue; and it may radiate to the eardrum of the same side and even down into the neck. Close attention to this distribution helps distinguish it from trigeminal neuralgia. It may also be imitated by herpes zoster and by local disease (either vascular, neoplastic, or inflammatory) of the ninth cranial nerve. In such cases, differentiation from neuralgia can be made by the discovery of sensory impairment in the area affected and by involvement of neighboring cranial nerves by the disease process. The only effective treatment is root section of the ninth cranial nerve.

GENICULATE NEURALGIA

Geniculate neuralgia is a theoretic possibility but pain of this type is nearly always part of herpes oticus, the syndrome of Ramsey Hunt. Pain is distributed to the eardrum and herpetic lesions are seen in the external auditory canal or on the surface of the pinna. Facial paralysis is commonly seen in association with pain. Again, herpes oticus must be distinguished from organic disease of the geniculate ganglion and seventh cranial nerve, such as metastatic or primary tumor, aneurysm, or inflammatory processes. In such case, areas of anesthesia and the involvement of other neighboring cranial nerves will serve to make the distinction.

Neuralgias may be seen in almost any other cephalic nerves and several types have been described, such as neuralgia of the posterior auricular nerve and of the occipital nerve. In all cases, diagnosis rests again upon the presence of the classical characteristics of neuralgic pain and upon the distribution in the area of the nerve involved. In each case treatment by injection or by surgical section is the only effective remedy.

8 S. Michigan Ave.

EDITORIALS

The 1957 annual meeting

The Annual Meeting of the Illinois State Medical Society will be held at the Hotel Sherman, Chicago, on May 21-24, 1957. The preliminary program for this meeting is published in this issue of the Illinois Medical Journal.

Some new features have been added this year, in addition to the very fine scientific papers which have been scheduled. The first meeting of the House of Delegates will be held on Tuesday morning, the second meeting on Thursday morning, and the third, and shorter session, on Thursday evening. At this last meeting, the regular election will be scheduled, and the induction of the President-elect to the office of President of the Society will also be scheduled for the evening session.

The Public Relations dinner meeting is scheduled for Tuesday evening and a fine program has been arranged. Following that meeting, about 9:15 P.M., the Woman's Auxiliary will have their Beau Belle Ball, in the Bal Taberin. A fine orchestra has been engaged, and along with high class entertainment, there will be dancing. All members, exhibitors and guests are invited to attend this late evening gathering.

The annual dinner as usual, is scheduled for Wednesday evening, May 22. An interesting program is being arranged, and a large attendance should be on hand. This program will also appear in the May Journal.

Section meetings are scheduled for the morning and the general assembly programs for the afternoons, Tuesday, Wednesday and Thursday. An interesting program has been arranged for all day Friday, the basic subject being "Medicine and the Law". The members of the Illinois Bar Association will participate in this interesting program. In the afternoon the Legal Department of the American Medical Association will be in charge of the program, at which time they will stress the medical witness—the right and the wrong procedures will be shown in the mock trials to be scheduled.

It is hoped that we will have an unusually large attendance and enjoy the many features which have been added for the 1957 annual meeting. Complete details and the official program will be published in the May issue of the Illinois Medical Journal.

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The right to be aborted

A housewife was brutally assaulted and raped. The woman became pregnant and appealed to a physician but when he tried to obtain sanction for a legal abortion he was stopped at every corner.

According to a comment in the American Journal of Psychiatry, the laws of most states follow a pattern similar to those in Colorado. "A miscarriage or abortion may be induced legally only with intent to save the life of such a woman or to prevent serious and permanent bodily injury to her."



Speaker's table at Legislative Dinner

The comment continues: "Apparently no physician was courageous enough to perform an operation not specifically authorized by law, however clearly it might be indicated on humanitarian or simple common sense grounds in any civilized community."

But the district attorney made a statement that covers the issue adequately and might serve as a pattern for Colorado and other states to follow to amend the law: "The law could be amended so that any female person who was the victim of a forcible rape, or any female child under the age of consent who was raped, resulting in pregnancy, would have a right to be aborted."

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Legislature guests of society at dinner on traffic safety

The Illinois State Medical Society on March 12 was host to Gov. Stratton, his official family and members of the Legislature at a dinner in the Leland Hotel, Springfield.

Theme of the occasion was Traffic Safety, with talks on the subject by Gov. Stratton and Dr. Fletcher D. Woodward, Charlottesville, Va., chairman of the American Medical Association's committee on medical aspects of automobile crash injuries and deaths.

Gov. Stratton a few hours before the dinner had presented his message to a joint session of the General Assembly. Among other things, this had called for an absolute speed limit law as the major plank in a traffic safety program. He also had asked that the state police force be doubled to 1,200 men; that a stronger curb be put on drunken drivers; that a system of chemical tests for drunkenness be set up; that physicians be required to report physical or mental disabilities of patients which might make them potentially dangerous drivers and that driver training schools be established.

Speaking at the dinner, Gov. Stratton said this program had the same elements as that of medicine's—"the saving of life and the prevention of suffering." He asked for "close correlation between medical skill and traffic safety."

Dr. Woodward presented the physician's side of the problem. He pointed out that automobile manufacturers can halve traffic deaths by applying existing research findings to the construction of motor cars.

Some makers are installing safety devices, but he said "if such a program could be made competitive by public demand instead of size, horsepower, acceleration and speed, then the day would soon dawn when the death and injury rate would start subsiding."

He said several bills providing for minimum safety standards had been introduced in Congress and that many state legislatures are considering similar measures. He warned that if the automobile industry did not take heed it may be regulated by a federal agency.

Dr. Woodward said three factors stand out as causes of the tragic death toll: speed, drunken

driving and poorly designed automobiles from a safety standpoint. He emphasized the importance of curtailing the drinking drivers who cause one-fourth of fatal crashes, and urged a compulsory chemical test to determine drunkenness in suspected individuals, also a mandatory jail sentence upon conviction.

He recommended the establishment of more approved public and private driving schools, and referral clinics staffed by physicians and psychologists to pass on the fitness of repeat offenders, drivers over 65 and those referred by court, police or physician.

Dr. F. Garm Norbury, Jacksonville, immediate past president of the Illinois State Medical Society, was toastmaster.

Arrangements for the dinner, attended by about 300, were handled by Dr. Jacob E. Reisch, Springfield, councilor for the fifth district, and Walter L. Oblinger, associate counsel of the Society.

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British negotiate fees

The Negotiating Committee met the Minister of Health and the Joint Parliamentary Under-Secretary of State for Scotland on Friday last week. Sir Russell Brain summed up the position at a press conference subsequently when he said that this was not merely a pay claim but a crisis of confidence that went to the roots of the relations between the government and the medical profession. And this is the keynote of the widespread comment in the national press. A leading article in the *Times* considers that the government ought to be ready to discuss some adjustment of rewards now." The article ends thus: "If deadlock ensues — the omens are unfavorable — the government will be as much to blame as anyone else for a dispute that could only injure the public." The Manchester *Guardian* concludes a leading article with these words: "It is the government's bleakly negative attitude so far which has stirred the doctors to their present wrath." The *Economist* observes that doctors "know only too well that the government always will be as firm with professional organizations as it will be weak with trade unions." It adds. "On the whole, therefore, the main responsibility for breaking the present deadlock lies with the Minister of Health." The *New Statesman* and *Nation* notes that "the Minister of Health's stupidly brusk rejection of it (the present claim) has aroused an ugly mood." "Legalistically," it adds, "the doctors have a strong case; the pledge to honor the Spens formula was repeatedly given when the Health Service was launched. The least the government can do is to offer to re-negotiate it."

Conservative, Liberal, and Socialist comment is aimed accurately at these two things: The government's obligation, whether legal or moral, to consider the profession's strong case for taking a stand on the Spens formula, and the Minister of Health's curt and brusk rejection of a patient and painstaking presentation of it. And this is quite apart from some press opinion that doctors may generally be better off than some professions or that, under the Spens terms, doctors would apparently be given immunity against the effects of rises in the cost of living; the punitive action of income tax at least takes care of this, apart from its deadly levelling effect and discouragement of that extra effort without which a society sinks into a condition of apathetic mediocrity. The medical profession is properly concerned with its own welfare. And this is not just financial. It is worried to see more and more of its members trying to emigrate to other countries; and these are not only the younger men fretting at the present frustrations of contemporary England and finding it hard to make their way in the world and support growing families. *Editorial. Negotiations Continued. Brit. M.J. Jan.* 12, 1957.

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The Iowa suit

The vigorously contested suit between the Iowa State Medical Society and the Iowa Hospital Association concerning the hospital-physician relationships of radiologists and pathologists apparently has been settled. A joint declaration has been ratified by the policy making bodies of both groups and it is expected that the appeal to the Supreme Court will soon be dismissed. The highlights of the joint agreement are:

1. There cannot be an employer-employee relationship between a hospital and a physician.
2. Radiology and pathology services are medical services.
3. Bills for radiology and pathology services must be submitted in the physician's name.

4. Radiology and pathology services that have been paid for by Blue Cross in the past will now be paid for by Blue Shield.

5. Hospitals may own and maintain laboratory and X-ray facilities and may operate them within the purview of the Joint Declaration.

6. Hospitals are to employ technologists and technicians unless it is mutually agreed otherwise.

7. The employment, discharge, and disciplining of technologists and technicians and the establishment of fees are to be accomplished by mutual agreement between the doctor and the hospital with the Joint Committee of the hospital resolving any differences.

8. Hospitals are not to interfere with professional medical acts of the doctor or technologists and technicians under his supervision.

9. A contract may be oral or written and shall provide for compensation as agreed to by the parties involved, but any compensation arrangement must conform to the principles contained in the Joint Declaration.

10. By unanimous agreement of the six conferees the Joint Declaration is limited to resolving problems of radiology and pathology. This grew out of the belief that if agreement could be reached in these specific areas it would make it easier to resolve other problems that may exist.

11. Local settlement between doctors and hospitals is stipulated in the agreement.

A complete copy of the joint declaration of the hospital-physician relationships may be obtained by writing to Mr. Donald L. Field Taylor, Executive Secretary, Iowa State Medical Society, 529 36th St., Des Moines, 12, Iowa. *Am. Soc. Anesthesiol. News Letter, Jan.* 1957.

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Medicine on postage stamps

The United States post office department on January 15 issued a 3c stamp to commemorate the production of an effective vaccine to prevent paralytic poliomyelitis. It carries the inscription: "Honoring Those Who Helped Fight Polio." A shield bears the caduceus.

Foreign postage stamps of recent issuance and of interest to collectors of stamps with a medical significance include the following:

Austria — A 2.40 schilling stamp to commemorate the centenary of the birth of Dr. Wagner-Jauregg (1857-1940), founder of the Vienna School of Medicine and 1927 Nobel Prize winner.

Belgium — A seven-value tuberculosis fund set. The low-value issues show the doubled-barred Cross of Lorraine on the sail of a ship; the others an examination of an infant, an X-ray examination and the rehabilitation of patients recovering from tuberculosis.

China (Communist) — Two stamps bearing the portrait of Dr. Sun Yat-Sen to mark the 90th anniversary of his birth and bearing the inscription: "Our revolution in future will fail utterly if we do not follow Soviet Russia."

Cuba — Four one-centavo stamps for the annual National Tuberculosis Fund.

Finland — The University Clinic in Helsinki is pictured on a 30 markka stamp to commemorate the 200th anniversary of the public health services. Four stamps for the Finnish Red Cross were issued.

France — Two Red Cross stamps were issued; 12 francs plus 4 francs, and 15 francs plus 5 francs.

German Federal Republic — Symbolic figures of a mother, midwife and a nurse, and portrait of Dr. Ignatz Semmelweiss, who pointed the way to conquest of childbed fever, are the subject of four semi-postals.

Iran — A 6-rials stamp honoring the International Health Organization features a caduceus over a map of the world.

Liberia — A 5 plus 5 c stamp shows two people looking through microscopes; inscriptions are: "Liberian Government Hospital," and "Research Today, Health Tomorrow."

Netherlands New Guinea — Four stamps were issued with a surcharge for leprosy relief in that country.

Philippines — A wooden statue of the Sacred Heart which Dr. Jose Rizal, Philippine patriot, carved when he was 13 years old, is pictured on 5 and 20 centavos stamps.

Romania — A 55b Red Cross stamp shows a nurse.

Turkey — A 25-kurus Red Crescent stamp pictures a mobile chest X-ray unit.

Venezuela — The University City Clinical Hospital is pictured on the 20c, 25c and 30c values of a nine-value air mail series.

PRELIMINARY PROGRAM

for the

One Hundred Seventeenth

ANNUAL MEETING

of the

ILLINOIS STATE MEDICAL SOCIETY

May 21, 22, 23, 24, 1957

Hotel Sherman **Chicago**

PROGRAM SUMMARY

TUESDAY, MAY 21

9:00 House of Delegates — first meeting
Section on Eye, Ear, Nose and Throat
Section on Obstetrics and Gynecology
Section on Anesthesiology
Section on Cardiovascular Disease

LUNCHEONS:
Section on Anesthesiology

1:30 GENERAL ASSEMBLY
3:30 Section on Radiology
6:00 Public Relations Dinner
9:30 Beau Belle Ball

WEDNESDAY, MAY 22

9:00 Section on Eye, Ear, Nose and Throat
Section on Pediatrics
Section on Surgery
Section on Pathology

LUNCHEONS:
Illinois Chapter, American Academy of Pediatrics
Section on Pathology
Illinois Academy of General Practice
Fifty Year Club

1:30 GENERAL ASSEMBLY
7:00 THE ANNUAL DINNER

THURSDAY, MAY 23

8:30 Women Physicians' Breakfast
9:00 Second Meeting — HOUSE OF DELEGATES
Physicians' Association — Department of Public Welfare
Section on Medicine
Section on Allergy
Section on Dermatology
Section on Preventive Medicine and Public Health
Illinois Chapter, American College of Chest Physicians

LUNCHEONS:
Section on Dermatology
Illinois Chapter, American College of Preventive Medicine
Phi Chi Fraternity
Illinois Chapter, American College of Chest Physicians

1:30 GENERAL ASSEMBLY
6:00 Loyola University Alumni Dinner
9:00 Third Meeting — HOUSE OF DELEGATES

FRIDAY, May 24

9:00 Joint Meeting — Illinois State Bar Association, Illinois State Medical Society
12:30 Luncheon
1:30-4:30 Mock Trial Demonstration
2:00 Illinois Association of Blood Banks

Meetings of the House of Delegates

(1) Tuesday, May 21

9:00 a.m. The first meeting of the House of Delegates will be called to order by the President, F. Lee Stone, for:

The Reports of Officers, Councilors, Committees, etc.

The introduction of resolutions, and for the transaction of any other business which may come before the House

THE COMMITTEE ON CREDENTIALS will meet at 8:00 a.m. Tuesday morning, May 21, in the entrance way to the Louis XVI Room. Delegates desiring to be certified as the official representatives of their county medical societies must present their credential cards to this committee.

(2) Thursday, May 23

9:00 a.m. The second meeting of the House of Delegates will be called to order by the President to hear those reports of Reference Committees ready to be presented.

(3) Thursday, May 23

8:30 p.m. The third (and last) meeting of the House of Delegates will be called to order by the President to hear those reports of Reference Committees remaining to be presented;

For the election of officers, councilors, committee members, delegates and alternate delegates to the American Medical Association, and for the transaction of any other business to come before the House.

At the close of this last meeting, Lester S. Reavley will be installed as the new President of the Illinois State Medical Society, and will receive the official gavel from the retiring President, F. Lee Stone.

Programs for Tuesday, May 21, 1957

SECTION ON EYE, EAR, NOSE and THROAT

Tuesday Morning, May 21, 1957

Chairman ..... G. LeRoy Porter, Urbana
Secretary ..... Pierce Theobald, Chicago
Crystal Room

9:00 TUBERCULOUS ULCER OF THE CONJUNCTIVA — Case report.
Earl H. Merz, Chicago, Northwestern University Medical School, St. Luke's Hospital
John J. Walsh, Chicago, St. Luke's Hospital

9:10 LOSS OF ANTERIOR CHAMBER FOLLOWING CATARACT SURGERY
George Wyman, Peoria

9:30 DISCUSSION

9:40 CLINICALLY MALIGNANT LESIONS OF THE NOSE AND PARANASAL SINUSES
Arthur L. Ratko, Chicago, University of Illinois College of Medicine, St. Luke's Hospital

10:00 DISCUSSION

10:10 NON-PERFORATING INJURIES OF THE ANTERIOR SEGMENT
Clarence V. Ward, Peoria

10:30 DISCUSSION

10:40 PROBLEMS IN THE FUTURE OF MOBILIZATION SURGERY
Jerome A. Hilger, St. Paul, Minn., Clinical Professor of Otolaryngology, University of Minnesota College of Medicine, Minneapolis, Minn.

11:00 DISCUSSION

11:10 BUSINESS MEETING AND ELECTION OF 1958 SECTION OFFICERS

11:30 ADJOURNMENT TO VIEW EXHIBITS

SECTION ON OBSTETRICS AND GYNECOLOGY

Tuesday Morning, May 21, 1957

Chairman ..... Carl Greenstein, Champaign
Secretary ..... Vincent C. Freda, Chicago
Old Chicago Room No. 101

9:00 SYMPOSIUM: REPORT OF CASE STUDIES OF ILLINOIS MATERNAL WELFARE COMMITTEE OF ILLINOIS STATE MEDICAL SOCIETY
Frederick H. Falls, Oak Park, Presiding Professor of Obstetrics and Gynecology, University of Illinois College of Medicine
HEMORRHAGE: Willard C. Scrivner, East St. Louis
ECLAMPSIA: Worling R. Young, Geneseo
ANESTHESIA: Robert R. Hartman, Jacksonville
INFECTION: Ralph N. Redmond, Sterling
DOES ENDOMETRIOSIS CAUSE ABNORMAL UTERINE BLEEDING?
Melvyn A. Bayly, Chicago
TREND IN MANAGEMENT OF CANCER OF CORPUS
Charles P. McCartney, Chicago, Assistant Professor of Obstetrics and Gynecology, University of Chicago College of Medicine
CLINICAL ASPECTS OF EXFOLIATIVE CYTOLOGY
Harold A. Kaminetzky, Chicago
INCIDENCE OF CANCER IN GERIATRIC WOMAN
Howard I. Ganser, Chicago

ELECTION OF 1958 SECTION OFFICERS

11:30 ADJOURNMENT TO VIEW EXHIBITS

SECTION ON ANESTHESIOLOGY

Tuesday Morning, May 21, 1957

Chairman ..... E. M. Dewhirst, Danville
Secretary ..... Herman J. Nebel, East St. Louis
Assembly Room

9:10 "ANESTHESIA PROBLEMS IN TRAUMA"
James A. Felts, Marion

9:40 "OBSTETRICAL ANALGESIA & ANESTHESIA"
Arthur T. Shima, Oak Park

10:10 RECESS TO VIEW EXHIBITS

10:40 "NITROUS OXIDE & L-DROMORAN"
Edward O. Kraft, St. Louis

11:10 "PRESENT STATUS OF CONDUCTION ANESTHESIA IN SURGERY, OBSTETRICS & THERAPEUTICS"
Robert A. Hingson, Cleveland, Ohio, Professor of Anesthesia, Western Reserve University

11:40 BUSINESS MEETING — ELECTION OF 1958 SECTION OFFICERS

12:00 SECTION LUNCHEON

SECTION ON CARDIOVASCULAR DISEASE

Tuesday Morning, May 21, 1957

Chairman ..... Emmet F. Pearson, Springfield
Secretary ..... George C. Sutton, Evanston
Gold Room No. 114

9:00 "SELECTION OF PATIENTS FOR MITRAL COMMISSUROTOMY"
Wright Adams, Chicago, Professor of Medicine, University of Chicago School of Medicine

9:20 "HAZARDS IN USE OF HYPOTENSIVE DRUGS"
Chauncey Maher, Jr., Springfield

9:40 "RADIATION IN CARDIOLOGY"
Ralph G. Willy, Evanston, Professor of Radiology, Northwestern University Medical School

10:00 RECESS TO VIEW EXHIBITS

10:40 "LONG-TERM ANTI-COAGULENT THERAPY IN THE MANAGEMENT OF CARDIAC INFARCTION"
Edward Caunaday, East St. Louis
"IDIOPATHIC CARDIOMEGALY IN ADULTS"
Robert L. Levy, New York, Professor Emeritus, Columbia University College of Physicians and Surgeons

BUSINESS MEETING AND ELECTION OF 1958 SECTION OFFICERS

SECTION ON RADIOLOGY

Tuesday Afternoon, May 21, 1957

3:30 p.m.

The guest moderator of the film reading session of the Section on Radiology will be Benjamin Felson, Professor of Radiology, University of Cincinnati College of Medicine, and Director of the Department of Radiology at Cincinnati General Hospital.

Following the scientific portion of the program, a business meeting and the election of Section Officers for 1958 will be held.

General Assembly

The Ballroom

Tuesday Afternoon, May 21, 1957

Presiding ..... Emmet F. Pearson, Springfield
Assisting ..... Hildegarde A. Schorsch, Chicago

1:30 Opening of the General Assembly
F. Lee Stone, Chicago, President, Illinois State Medical Society

1:40 NEWER CONTRAST METHODS IN DIAGNOSTIC ROENTGENOLOGY
Benjamin Felson, Cincinnati, Ohio, Professor of Radiology, University of Cincinnati College of Medicine, and Director of Department of Radiology, Cincinnati General Hospital

2:00 SOME CURRENT VIEWS OF CARDIAC INFARCTION
Robert L. Levy, New York, Professor Emeritus of Medicine, Columbia University College of Physicians and Surgeons

2:20 NUTRITION AS A FACTOR IN COMMON DISEASE STATES
Robert E. Olson, Pittsburgh, Pennsylvania, Professor and Head of Department of Biochemistry and Nutrition, Graduate School of Public Health, Lecturer in Medicine, School of Medicine, University of Pittsburgh

2:40 RECESS TO VIEW EXHIBITS

Presiding ..... E. M. Dewhirst, Danville
Assisting ..... G. LeRoy Porter, Urbana

3:30 POLIOMYELITIS IN 1956
Neal Nathanson, Atlanta, Georgia, Surgeon, United States Department of Public Health

3:50 OXYGEN IN THE DOCTOR'S SATCHEL
Robert A. Hingson, Cleveland, Ohio, Professor of Anesthesia, Western Reserve University

4:10 THE GENERAL PRACTICE APPROACH TO DEAFNESS
Jerome A. Hilger, St. Paul, Minnesota, Clinical Professor of Otolaryngology, University of Minnesota College of Medicine, Minneapolis

Here's an interesting and entertaining evening planned for you . . .

PUBLIC RELATIONS DINNER

Tuesday Evening, May 21, 1957

6:00 p.m.

The Public Relations Dinner (sponsored by the Committee on Medical Service and Public Relations of the Illinois State Medical Society) will be held for the fifth consecutive year.

Any member of the Society interested in public relations and the many phases of this important work, will be most welcome to attend. The wives of all physicians attending the dinner and program are most cordially invited. The importance of the public relations work of the Auxiliary is becoming more and more recognized by the members of the State Society.

Mr. Paul Jones, Director of Public Relations for the NATIONAL SAFETY COUNCIL, Chicago, will be the speaker of the evening. Medicine has become deeply interested in highway safety, and the public relations phase of this vital problem will provide an excellent program.

AFTER THE P.R. DINNER
"THE BEAU BELLE BALL"

will be staged in the Bal Tabarin from 9:30 p.m. until 12:30. The Committee from the Auxiliary planning the party is composed of Mrs. Harlan English and Mrs. Donald D. Spicer of Danville, and the members of the Vermilion County Auxiliary.

All physicians attending the 1957 annual meeting and all technical exhibitors will be the guests of the Illinois State Medical Society.

There will be entertainment and dancing. Everyone is welcome.

Programs for Wednesday, May 22, 1957

SECTION ON EYE, EAR, NOSE AND THROAT

Wednesday Morning, May 22, 1957

Chairman ..... G. LeRoy Porter, Urbana
Secretary ..... Pierce Theobald, Chicago
Crystal Room

9:00 BRONCHOLOGICAL ASPECTS OF PULMONARY FUNCTION TESTS
Albert H. Andrews, Jr., Chicago, Associate Clinical Professor of Bronchoesophagology, University of Illinois College of Medicine

9:20 DISCUSSION

9:30 ATOMIC ENERGY AND THE EYE
David V. L. Brown, Chicago, University of Illinois College of Medicine

9:40 DISCUSSION

10:00 SURGICAL PROBLEMS IN THE TREATMENT OF ADVANCED CARCINOMA OF THE HEAD AND NECK
William G. Hemenway, Chicago, University of Chicago

10:20 DISCUSSION

10:30 THERAPY OF CLOSED ANGLE GLAUCOMA
Robert W. Lennon, Joliet

10:50 DISCUSSION

11:00 OTOLARYNGOLOGIC ASPECTS OF THE CLEFT PALATE
Emanuel M. Skolnik

11:20 DISCUSSION

11:30 ADJOURNMENT TO VIEW EXHIBITS

SECTION ON PEDIATRICS

Wednesday Morning, May 22, 1957

Chairman ..... Noel G. Shaw, Evanston
Secretary ..... Raymond Eveloff, Springfield
Louis XVI Room

9:00 "HYPERTHYROIDISM IN CHILDREN"
John S. Hyde, Oak Park, Assistant Professor of Pediatrics, University of Illinois College of Medicine
I. Pat Bronstein, Chicago, Clinical Professor of Pediatrics University of Illinois College of Medicine

9:20 "JUVENILE DELINQUENCY"
James Gillespie, Urbana, Carle Clinic

9:40 "CAUSATIVE FACTORS OF BRAIN DAMAGE IN INFANTS AND CHILDREN"
Charles S. Textor, St. Francis Hospital, Evanston

10:00 "PRACTICAL ASPECTS OF FLUID BALANCE IN CHILDREN"
Michael J. Sweeney, Associate Medical Director, Mead Johnson, Evansville, Indiana

10:20 RECESS TO VIEW EXHIBITS

10:50 "LYMPHOMA"
Harold W. K. Dargeon, New York, Associate Professor, Clinical Pediatrics, Cornell University Medical College

11:20 SYMPOSIUM: "THE USE OF TRANQUILIZING DRUGS IN CHILDREN —"IN NEUROMUSCULAR DISORDERS"
Meyer A. Perlstein, Chicago, Associate Professor of Pediatrics, Northwestern University Medical School
IN PSYCHIATRIC STATES
Harold E. Himwich, Galesburg, Galesburg State Research Hospital
IN MENTALLY RETARDED
Janet D. Rowley, Chicago, Research Fellow, Julian Levinson Foundation
FURTHER POTENTIAL USES AND HAZARDS
James Toman, Ph.D., Chicago, Assistant Professor, Department of Physiology and Pharmacology Chicago Medical School

12:15 BUSINESS SESSION — Election of 1958 Section Officers.

12:25 LUNCHEON
Illinois Chapter, American Academy of Pediatrics
All physicians interested in problems and welfare of children are invited to attend. The luncheon will adjourn in time for the opening of the General Assembly Wednesday afternoon at 1:30 at which will be presented The President's Address, the Oration in Medicine and the Oration in Surgery.

SECTION ON SURGERY

Wednesday Morning, May 22, 1957

Chairman ..... David A. Bennett, Canton
Secretary ..... Richard H. Lawler, Chicago
Old Chicago Room No. 101

9:00 "THE ACUTE ABDOMEN (TRAUMA)"
William M. McMillan, Chicago, Assistant Professor of Surgery, Northwestern University Medical School; Professor of Surgery Cook County Graduate School of Medicine; Staff — Cook County and Wesley Memorial Hospitals

9:15 "INTUSSUSCEPTION IN THE ADULT"
Harold P. McGinnes, Bloomington

9:30 "PSEUDOCYST OF PANCREAS DUE TO TRAUMA"
Lorrin D. Whittaker, Peoria

9:45 "OLIGURIA AND ANURIA"
Vincent J. O'Conor, Chicago, Professor and Head of Department of Urology, Northwestern University Medical School; Chairman of Department of Urology, Wesley Memorial Hospital

10:00 RECESS TO VIEW EXHIBITS

10:30 PANEL SYMPOSIUM — "CARCINOMA OF THE SIGMOID COLON AND RECTUM"

Moderator: Karl A. Meyer, Chicago, Professor Emeritus Northwestern University Medical School; President, Chicago Medical Society; Chairman, Department of Surgery and Superintendent of Cook County Hospital; Chairman, Department of Surgery; Columbus Memorial Hospital

COLLABORATORS: R. Kennedy Gilchrist, Chicago, Professor of Surgery, University of Illinois College of Medicine; Attending Surgeon, Cook County, Presbyterian and Ravenswood Hospitals

Everett P. Coleman, Canton, President, Western Surgical Society; President, Illinois Surgical Society; Chairman of Staff, Graham Hospital, Canton

Vincent J. O'Conor, Chicago, Professor and Head of Department of Urology, Northwestern University Medical School; Chairman, Department of Urology of Wesley Memorial Hospital

Edwin M. Miller, Chicago, Professor of Surgery, University of Illinois College of Medicine; Attending Surgeon, Presbyterian Hospital

11:45 BUSINESS MEETING AND ELECTION OF 1958 SECTION OFFICERS.

SECTION ON PATHOLOGY

Wednesday Morning, May 22, 1957

Chairman ..... Dennis B. Dorsey, Danville

Secretary ..... Frederick Bauer, Chicago

Jade Room No. 103

9:00 PANEL DISCUSSION: The Clinician and Pathologist at the Bedside

MODERATOR: Dennis B. Dorsey, Danville

1. A CLINICIAN LOOKS AT NEW TESTS —A Practical Evaluation Norman B. Roberg, Chicago
2. LABORATORY DATE — Significant or Meaningless. William S. Hoffman, Chicago
3. IS YOUR LABORATORY RELIABLE? Welland A. Hause, Decatur
4. THE UNSOLVED LABORATORY PROBLEMS OF A SMALL COMMUNITY HOSPITAL, S. B. Furby, Paxton

INTERMISSION FOR VIEWING EXHIBITS

5. WHAT THE CLINICIAN EXPECTS FROM THE PATHOLOGIST — AND DOESN'T GET. Thomas Sellett, Sterling
6. WHAT THE CLINICIAN CAN GET FROM THE PATHOLOGIST — IF HE ASKS, George Milles, Chicago, Pathologist and Director of Laboratories, Augustana Hospital, and Professor of Pathology, University of Illinois College of Medicine

QUESTION AND ANSWER PERIOD

Closing remarks: Dennis B. Dorsey, Moderator

LUNCHEON — AND BUSINESS MEETING — Election of 1958 Section Officers

The members of the Illinois State Medical Society attending the meeting are urged to submit questions for discussion to the MODERATOR, Dr. Dennis B. Dorsey, 812 North Logan Avenue, Danville, Illinois:

CLIP THE FOLLOWING FORM AND MAIL

Please discuss the following questions at the meeting of the Section on Pathology:

1.
2.
3.

Signature (optional)

ILLINOIS ACADEMY OF GENERAL PRACTICE

Wednesday Noon, May 22, 1957

Crystal Room

There will be a luncheon meeting of the Illinois Chapter of the Academy of General Practice at 11:45 o'clock on Wednesday, May 22.

Since this meeting must adjourn at 1:30 in order for the physicians attending to be present at the General Assembly, the luncheon will start on time.

Members of the Academy and their friends may make their reservations with their Regional Chapter Secretary.

It is hoped that this second annual luncheon held in connection with the annual meeting of the Illinois State Medical Society, will be a successful one.

If you care to make your reservations direct with the Academy headquarters, you may write to Dr. H. Marchmont-Robinson, 14 East Jackson Boulevard, Chicago.

FIFTY YEAR CLUB LUNCHEON

Wednesday Noon, May 22, 1957

Old Chicago Room No. 101

Andy Hall, Chairman of the Fifty Year Club since its formation in 1937, will preside again this year at the annual complimentary luncheon honoring the members of the FIFTY YEAR CLUB.

All physicians who have been in the practice of medicine for fifty years or more are invited as guests of the Illinois State Medical Society at one of the most popular social functions held during the annual meeting.

Tickets for the luncheon are complimentary and may be secured at the ticket desk during the first day of the meeting, or from Doctor Hall.

Doctor Hall will send notices to all members of the FIFTY YEAR CLUB with a return postal card for reservations, and to enable the State Society to plan *adequate accommodations* for the luncheon.

General Assembly

The Ballroom
Wednesday Afternoon, May 22, 1957

Presiding ..... David A. Bennett, Canton
Assisting ..... Robert M. Hoyne, Urbana

1:30 THE PRESIDENT'S ADDRESS:
F. Lee Stone, Chicago, President, Illinois State Medical Society

2:00 THE ORATION IN MEDICINE:
To be announced

2:30 THE ORATION IN SURGERY:
William F. Mengert, Chicago, Head of the Department of Obstetrics and Gynecology, University of Illinois College of Medicine

3:00 RECESS TO VIEW EXHIBITS

Presiding ..... Noel G. Shaw, Evanston
Assisting ..... Carl Greenstein, Champaign

3:30 RETICULOENDOTHELIOSIS
Harold W. K. Dargeon, New York, Associate Professor, Clinical Pediatrics, Cornell University Medical College

3:50 THE ROLE OF SURGERY IN CANCER OF CERVIX
Willis E. Brown, Little Rock, Arkansas, Professor of Obstetrics and Gynecology, University of Arkansas School of Medicine

4:10 Speaker to be provided

The Annual Dinner

The Ballroom
Wednesday Evening, May 22, 1957
7:00 p.m.

The annual dinner this year will honor Dr. F. Lee Stone, Chicago, the retiring President of the Illinois State Medical Society.

The toastmaster will be the Immediate Past President, F. Garm Norbury of Jacksonville.

At the annual dinner, for the third year, the HEALTH PROGRESS AWARDS will be presented by the President to the individual and to the group contributing in an outstanding manner to the health and welfare of the citizens of Illinois.

The dinner speaker will be announced in the official program.

The Past Presidents and guests will be presented by the toastmaster, F. Garm Norbury, and the President's Certificate will be presented to F. Lee Stone by the Chairman of the Council, H. Close Hesseltine.

Programs for Thursday, May 23, 1957

WOMEN PHYSICIANS' BREAKFAST

Thursday Morning, May 23, 1957

8:00 a.m.

On Thursday morning, May 23, the women physicians registered at the 1957 annual meeting will be the guests of the Illinois State Medical Society at a breakfast meeting.

This annual breakfast has been held for several years, and the women physicians in attendance have enjoyed a complimentary breakfast and short and informal program before the opening of the scientific sessions at 9:00 a.m.

The chairman and members of her committee will be announced in the final program of the annual meeting to be published in the May Illinois Medical Journal.

SECTION ON MEDICINE

Thursday Morning, May 23, 1957

Chairman ..... Robert M. Hoyne, Urbana
Secretary .... William H. Wehrmacher, Chicago

Crystal Room

9:00 SYMPOSIUM ON DIABETES
Robert Clark, Chicago, Moderator, University of Illinois College of Medicine
Arthur R. Colwell, Jr., Evanston, Assistant Professor of Pediatrics, Northwestern University Medical School
Alvah L. Newcomb, Winnetka, Assistant Professor of Pediatrics, Northwestern University Medical School

10:00 RECESS TO VIEW EXHIBITS

10:30 CAPRICES OF INFECTIOUS MONOCULEOSIS
Sheldon E. Krasnow, Oak Park, Clinical Assistant Professor of Medicine, University of Illinois College of Medicine

10:50 PHLEBOTHROMBOSIS AND PULMONARY INFARCTION
Charles F. Downing, Decatur

11:10 GROUP PSYCHOTHERAPEUTIC APPROACH TO WEIGHT CONTROL
Katharine W. Wright, Chicago, W. Reed Brockback, Chicago
Discussion: M. David Allweiss, Chicago, Associate in Medicine, Northwestern University Medical School

11:30 BUSINESS MEETING — Election of 1958 Section Officers

SECTION ON ALLERGY

Thursday Morning, May 23, 1957

Chairman ..... Ellis Canterbury, Peoria
Secretary ..... Allan R. Feinberg, Chicago

Room No. 107

9:00 CAUSES OF DEATH IN BRONCHIAL ASTHMA
Robert Becker, Joliet

9:20 URTICARIAL PROBLEMS
John Sheldon, Ann Arbor, Michigan, Professor of Internal Medicine University of Michigan Medical School

9:40 PREVENTION OF HYPOSENSITIZATION REACTIONS
Leonard Harris, Peoria

10:10 RECESS TO VIEW EXHIBITS

10:30 PANEL DISCUSSION: FOOD ALLERGY
Leon Unger, Chicago
Helan C. Hayden, Chicago
Milton M. Mosko, Chicago
Abe Matheson, Chicago

11:30 BUSINESS MEETING and election of 1958 Section Officers

SECTION ON DERMATOLOGY

Thursday Morning, May 23, 1957

Chairman ..... Malcolm Spencer, Danville
Secretary ..... John M. McCuskey, Peoria

Old Chicago Room No. 101

SYMPOSIUM — THE MANAGEMENT OF COMMON SKIN DISEASES

COMMON CUTANEOUS MANIFESTATIONS OF VIRUS DISEASES
Malcolm Spencer, Danville, Chairman, Section on Dermatology

10:00 PANEL — THE MANAGEMENT OF WARTS
This panel will stress the treatment of all types of warts. Kodachromes of exemplary cases will be presented for discussion
MODERATOR: Julius E. Ginsburg, Chicago Associate Professor of Dermatology Northwestern University School of Medicine
Paul P. Boswell, Chicago
Myron H. Kulwin, Champaign
Oliver Rian, Peoria
Arthur C. Curtis, Ann Arbor, Michigan

10:30 RECESS TO VIEW EXHIBITS

11:00 PANEL — ECZEMA OF INFANCY AND CHILDHOOD
This panel will stress the treatment of different types of eczema in infancy and childhood. Kodachromes of exemplary cases will be presented for discussion
MODERATOR — Francis E. Senear, Chicago, Professor Emeritus, Department of Dermatology, University of Illinois School of Medicine
Frederick D. Malkinson, Chicago
Harold H. Rodin, South Bend, Indiana
Louis Rubin, Rockford
Cornelius A. VanderLaan, Chicago
Arthur C. Curtis, Ann Arbor, Michigan

12:00 LUNCHEON for members of the Section and their guests
BUSINESS MEETING and election of 1958 Section Officers

SECTION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH

Thursday Morning, May 23, 1957
Assembly Room

Chairman ..... Herbert Ratner, Oak Park
Secretary ..... Jackson P. Birge, Rock Island

9:00 a.m.
THE NEWER ASPECTS OF DIABETES
Carl A. Hedberg, Chicago
RADIATION OBVIATING NECESSITY FOR SURGERY IN THYROID DISEASE
Linden Seed, Chicago
PREVENTIVE ASPECTS OF RHEUMATIC FEVER
Gene H. Stollerman, Chicago
DEMONSTRATION OF NORMAL AND PATHOLOGICAL HEARD SOUNDS
Jacques M. Smith, Chicago
THE FUTURE OF SYPHILIS CONTROL
Evan W. Thomas, New York, Professor of Clinical Medicine (Syph.) New York University College of Medicine, New York

LUNCHEON .... Illinois Chapter AMERICAN COLLEGE OF PREVENTIVE MEDICINE
Thursday noon, May 23, 1957
Illinois Chapter

AMERICAN COLLEGE OF CHEST PHYSICIANS

Thursday Morning, May 23, 1957
Gold Room No. 114

8:30 a.m.

Murray Kornfeld, Executive Director of the American College of Chest Physicians will cooperate in providing the program for the Illinois Chapter of the American College of Chest Physicians' meeting during the state society session. The scientific program will be presented from 8:30 a.m. until noon.

LUNCHEON
Orchid Room No. 106

There will be a business luncheon following the scientific program which will adjourn in time for the physicians in attendance to be present at the General Assembly scheduled in the Ballroom at 1:30 p.m.

PHYSICIANS' ASSOCIATION OF THE Department of Public Welfare State of Illinois

Thursday Morning, May 23, 1957
Jade Room No. 103

The Physicians' Association of the Department of Public Welfare of the State of Illinois will hold its annual scientific program on Thursday morning, May 23.

Dr. Werner Tuteur, Clinical Director at Elgin State Hospital has been appointed as the Program Chairman, and the scientific papers to be presented will be outlined in the final program and published in the May issue of the Illinois Medical Journal.

PHI CHI FRATERNITY LUNCHEON

Thursday noon, May 23, 1957
Time Room No. 110

The Phi Chi Fraternity will have a luncheon meeting on Thursday noon, May 23. Dr. Jacob E. Reisch, Springfield, Editor of the Phi Chi Bulletin will be in charge of the plans.

All members of the fraternity are welcome to attend.

You may make reservations by writing to
Dr. Jacob E. Reisch
1129 South Second Street
Springfield, Illinois

General Assembly

The Ballroom
Thursday Afternoon, May 23, 1957

Presiding ..... Ellis Canterbury, Peoria
Assisting .....Malcolm Spencer, Danville

1:30 SOME INTERESTING FACETS OF THE COLLAGENOUS DISEASE PROBLEM
Arthur E. Curtis, Ann Arbor, Michigan, Professor and Chairman, Department of Dermatology and Syphilology, University of Michigan Medical School

1:50 THE GENERAL PRACTITIONER AND SYPHILIS
Evan W. Thomas, New York, Professor of Clinical Medicine (Syph.), New York University College of Medicine, New York

2:10 THE PREVENTION OF ALLERGIC REACTIONS
John M. Sheldon, Ann Arbor, Michigan, Professor of Internal Medicine, University of Michigan Medical School, Ann Arbor

2:30 RECESS TO VIEW EXHIBITS

Presiding ..... Dennis B. Dorsey, Danville
Assisting ..... Herbert Ratner, Oak Park

3:10 THE PATHOLOGIST AND YOUR PATIENT
George Milles, Chicago, Pathologist and Director of Laboratories, Augustana

Hospital. Professor of Pathology, University of Illinois College of Medicine.

3:30 PERSONALITY PROBLEMS IN TRAFFIC SAFETY
Mr. James Stannard Baker, Chicago, Northwestern University Traffic Institute

3:50 NARCOTISM AND ALCOHOLISM
Eugene Carey, Chicago, Chicago Police Department

LOYOLA UNIVERSITY ALUMNI DINNER
Thursday Evening, May 23, 1957

The Medical Alumni of Loyola University's Stritch School of Medicine will hold their annual dinner during the convention of the Illinois State Medical Society on Thursday evening, May 23.

In the past this dinner has been scheduled for 7:00 o'clock. However, this year, the dinner will be set for 6:00 p.m. so that all members of the House of Delegates who desire to attend, will be able to leave in time for the third and last session of the House, at 9:00 p.m. that same evening.

The program will be published in the May issue of the Journal.

Programs for Friday, May 24, 1957

Joint Meeting
ILLINOIS STATE BAR ASSOCIATION
ILLINOIS STATE MEDICAL SOCIETY
Friday, May 24, 1957

CHAIRMEN: Leo S. Karlin, Attorney at Law, Chicago
Leo P. A. Sweeney, M.D., Chicago

9:00 OPENING REMARKS:
Lester S. Reavley, President, Illinois State Medical Society, Sterling
James G. Thomas, President, Illinois State Bar Association, Champaign

9:10 THE DOCTOR AND THE COURTS
Irwin W. Roemer, Trial Attorney, Chicago
Interprofessional Relationship
Medical and Legal Concepts of Causation
Payments — for reports, court appearances, Subpoenas, Protection of fees.

9:30 MALPRACTICE
Charles M. Rush, Trial Attorney, Chicago
Impact of this type of Litigation as it effects doctors in their work.

9:50 PREPARATION OF MEDICAL AND LEGAL PHASES
Louis G. Davidson, Trial Attorney, Chicago
Before Trial and For Trial: Medical reports—Hospital Records—Office Records—Consultation—Question of Privileged Medical Communications.
Interprofessional Cooperation: Consultation before Trial and Conduct in Court Room.

10:10 MEDICAL DEMONSTRATIVE EVIDENCE
Leo S. Karlin, Trial Attorney, Chicago
Simplifying Medical Testimony: Medical drawings, Skeletons, Charts, Blackboards and other visual aids.

10:30 AS THE DOCTOR SEES THE COURT AND THE LAWYER
Carlo Scuderi, M.D., Orthopedic Surgeon, Chicago
Doctor-Lawyer Relationships: Cooperation—Conflicts
The Court: Preparation—the Summons —Awaiting call to the Stand. Conduct as a witness.

10:50 RECESS TO VIEW EXHIBITS

11:20 PANEL FOR QUESTIONS AND ANSWERS
MODERATOR: Leo P. A. Sweeney, M.D.
Irwin W. Roemer, Attorney
Charles M. Rush, Attorney
Louis G. Davidson, Attorney
Leo S. Karlin, Attorney
Carlo Scuderi, M.D., Surgeon

12:30 LUNCHEON

1:30 CHEMICAL TESTS FOR INTOXICATION: Scientific Background and Public Acceptance
Herman A. Heise, M.D., Milwaukee, Wisconsin
MOCK TRIAL DEMONSTRATION: Drunk Driving Case
Expert Medical Witness — Ralph E. DeForest, M.D., Secretary Council on Medical Physics, American Medical Association, Chicago.
Police Technician — Captain Robert F. Forkenstein, Indiana State Police, Indianapolis, Indiana
Arresting Officer — Joseph Cavanaugh, Chicago Police Department, Chicago
Defendant — George B. Larson, Assistant Director, Bureau of Exhibits, American Medical Association, Chicago.
Prosecuting Attorney — Edwin J. Holman, Law Department, American Medical Association, Chicago
Defense Attorney — William J. McAuliffe, Jr., Law Department, American Medical Association, Chicago
Judge — C. Joseph Stetler, Director, Law Department, American Medical Association, Chicago

4:30 Adjournment.

THE ILLINOIS ASSOCIATION OF BLOOD BANKS

Friday Afternoon, May 24, 1957

The Illinois Association of Blood Banks will hold its annual meeting on Friday, May 24. A scientific program will be presented from 2:00 to 4:00 o'clock, followed by a business meeting.

Details of the final program will be published in the May issue of the Illinois Medical Journal and in the official program for distribution at the registration desk during the meeting.

Dr. Donald R. Russ, secretary and treasurer for the Illinois Association, will submit the program material.

SCIENTIFIC EXHIBITS

The Committee on Scientific Exhibits is preparing another group of outstanding and educational exhibits for the education and interest of the physicians attending the 1957 annual meeting.

The Committee in charge of this important phase of annual meeting activity is:

Coye C. Mason, Chairman and Director, Chicago
Arkell M. Vaughn, Chicago
William E. Adams, Chicago
Leo M. Zimmerman, Chicago
L. W. Peterson, Chicago
Harold L. Method, Chicago
Everett P. Coleman, Canton
J. C. T. Rogers, Urbana

The list of exhibitors and the outline of the exhibits will be published in the May issue of the Illinois Medical Journal, and in the official program for distribution at the registration desk.

1957 Technical Exhibitors

Abbott Laboratories, Inc., North Chicago, Illinois
Audio-Digest Foundation, Glendale, California
Baby Development Clinic, Chicago, Illinois
Baker Laboratories, Inc., Cleveland, Ohio
Baxter Laboratories, Inc., Morton Grove, Illinois
Blue Cross-Blue Shield, Chicago, Illinois
Brooks Appliance Co., Chicago, Illinois
Chicago Pharmacal Company, Chicago, Illinois
Chicago Reference Book Company, Chicago, Illinois
Ciba Pharmaceutical Products, Inc., Summit, New Jersey
The Coca Cola Company, Atlanta, Georgia
Daniels Surgical & Medical Supplies, Chicago, Illinois
Dayless Manufacturing Company, Chicago, Illinois
Desitin Chemical Company, Providence, Rhode Island
Doho Chemical Corporation, New York, N. Y.
Eaton Laboratories, Norwich, New Jersey
Eisele & Company, Nashville, Tennessee
Eli Lilly & Company, Indianapolis, Indiana
Encyclopaedia Britannica, Chicago, Illinois
E. Fougera & Company, New York, N. Y.
Geigy Pharmaceuticals, Yonkers, New York
Great Books of the Western World Chicago
H. J. Heinz Company, Pittsburgh, Pennsylvania
Jackson-Mitchell Pharmaceuticals, Inc., Culver City, California
Lederle Laboratories, Pearl River New York
The Liebel Flarshiem Company, Cincinnati, Ohio
J. B. Lippincott Company, Philadelphia
Loma Linda Food Company, Arlington, California
S. E. Massengill Company, Bristol, Tennessee
Mead Johnson & Company, Evansville, Indiana
Medco Products Company, Tulsa, Oklahoma
The Medical Protective Company, Fort Wayne, Indiana
Merck & Company, Inc., Rahway, New Jersey
Merck-Sharp & Dohme, Philadelphia
V. Mueller & Company, Chicago, Illinois
National Live Stock & Meat Board, Chicago, Illinois
A. R. Nechin Company, Chicago, Illinois
Nordmark Pharmaceutical Laboratories, Irvington, New Jersey
Northern Illinois Medical Service, Inc., Rockford, Illinois
Parke, Davis & Company, Detroit, Michigan
Parker, Aleshire & Company, Chicago, Illinois
Pfizer Laboratories, Brooklyn, New York
Professional Management, Bloomington, Illinois
Profesray, Inc., Maywood, Illinois
Purdue Frederick Company, New York, N. Y.
Read and Carnrick, Jersey City, New Jersey
R. J. Reynolds Tobacco Company, Winston-Salem, North Carolina
A. H. Robins Company, Inc., Richmond, Virginia
J. B. Roerig & Company, Chicago, Illinois
The Sanborn Company, Cambridge, Mass.
W. B. Saunders Company, Philadelphia, Pennsylvania
Schering Corporation, Bloomfield, New Jersey
Julius Schmid, Inc., New York, N. Y.
G. D. Searle & Co., Chicago, Illinois
7-Up Developers Association, Chicago, Illinois
Sherman Laboratories, Detroit, Michigan
Smith, Kline & French Laboratories, Philadelphia, Pennsylvania
E. R. Squibb & Sons, New York, N. Y.
United States Tobacco Company, New York, N. Y.
The Upjohn Company, Kalamazoo, Michigan
Vitamin Products Company, Milwaukee, Wisconsin
Wallace Laboratories, New Brunswick, New Jersey
Winthrop Laboratories, New York, N. Y.
The Zemmer Company, Pittsburgh, Pennsylvania

Description of Technical Exhibits

ABBOTT LABORATORIES
Booth 56

The new sedative, tranquilizer and antihypertensive, NEMBU-SERPIN (R) Filmtabs (R) will be among the new products exhibited by Abbott Laboratories. Also shown will be the new nonbarbiturate hypnotic, PLACIDYL (R); and the new mood-improvement drug, DESBUTAL (R) Abbott will also exhibit ERYTHROCIN (R) Filmtabs, the antibiotic providing specific action against coccic infections; IBEROL (R) Filmtabs; OPTILETS (R) Filmtabs, high-potency therapeutic multi-vitamins; VI-DAYLIN (R), the homogenized mixture of seven vitamins; SELSUN (R): PENTOTHAL (R) SODIUM: and Abbott's complete line of intravenous solutions and equipment.

AUDIO-DIGEST FOUNDATION
Booth 66

Audio-Digest Foundation—a subsidiary of the California Medical Association — gives the busy physician an effortless tour through the best of current medical literature each week. This medical tape-recorded "newscast" — compiled and reviewed by a professional Board of Editors — may be heard in the physician's automobile, home or office. The Foundation also offers medical lectures by nationally-recognized authorities.

BABY DEVELOPMENT CLINIC
Booth 25

Baby Development Clinic invites doctors to learn about New Lifebuoy with TMTD. (TMTD is the new germicide developed by Lever Brothers). Medical brochure and other literature available. Also samples of New Lifebuoy for personal use and clinical testing. Learn why EVENFLO NIPPLES with PATENTED TWIN VALVES enable babies to nurse in comfort as at the breast. See other new Evenflo feeding products. Become acquainted with THE BOOK HOUSE, a reading plan for parents and children from infancy to high school.

BAKER LABORATORIES INC.
Booth 8

You are invited to visit our booth where Baker's Modified Milk and Varamel, two successful products for infant feeding, are on display.

Baker representatives will be glad to discuss the practical application of Grade A milk, adjusted fat composition, zero curd tension, synthetic vitamins and other important factors which help to eliminate many of the problems in modern infant feeding.

BAXTER LABORATORIES INC.
Booth 51

Baxter Laboratories will present the Travert-Electrolyte solutions for meeting parenteral requirements for both carbohydrates and electrolytes. Travert, 10% may be given in the same infusion time as 5% dextrose, with greater utilization.

See the new INCERT, the new, safe, economical way to supplement parenteral solutions without the risks associated with the use of syringe and needle. New Plexitron sets for safe pressure transfusions, scalp vein infusions and other special procedures will be demonstrated.

BLUE CROSS-BLUE SHIELD
Booths 20 and 21

BROOKS APPLIANCE COMPANY INC.
Booth 4

The Brooks Appliance Company will exhibit and describe in detail the technique of applying the combination pressure bandages. The moist medicated Primer Bandage plus the Dalzoflex Elastic Adhesive which are used in treating leg ulcers and phlebitis. As distributors of Anatomical Appliances, our representative will be in attendance to answer questions and explain in detail our Sacral, Sacral-Lumbar and Dorsal Lumbar supports. Elastic Stockings, the Nulast Elastic Crepe Bandages and Surgical Instruments will also be displayed.

CHICAGO PHARMACAL COMPANY
Booth 57

CHICAGO REFERENCE BOOK COMPANY
Booth 67

It is impossible to think without words. Moreover, words are used in speaking and writing, two forms of expressing our thoughts. To use the right word at the right time you need Webster's New International Dictionary, Second Edition, with Reference History.

We invite you to inspect it at booth No. 67 where our representatives will explain the functions and contents of this great unabridged dictionary. Ask about our special offer.

CIBA PHARMACEUTICAL PRODUCTS INC.
Booth 9

Ciba is featuring two prescription specialties — RITALIN, a new mild stimulant-antidepressant and DORIDEN, a nonbarbiturate hypnotic-sedative. RITALIN raises depressed patients to normal levels of psychomotor activity without amphetamine-like over-stimulation or depressive rebound. Nonhabit-forming DORIDEN is already being widely used as a safe, barbiturate replacement. Representatives will be present to answer queries on these very effective agents.

THE COCA COLA COMPANY
Booth 17

Ice-cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company of Chicago, Inc., and The Coca-Cola Company.

DANIELS SURGICAL AND MEDICAL SUPPLIES
Booths 15 and 16

DANIELS on the north end of the Exhibition Hall will feature this year the newest and most modern type of medical furniture and equipment.

Such lines as HAMILTON's new medical furniture pieces, RITTER's "Time saving" and "Energy saving" electrically operated examining table. BURDICK's — EKG & new portable Ultra Sonic unit. CASTLE and AMERICAN's Hi-Speed Autoclaves. A new 1½ cu. ft. Biological Refrigerator. WELCH ALLYN's Disposable otoscope specula "Kleen-Spec"; — LUXO's New Chrome plate Examining Lamps. The latest in Proctoscopes, Head Lamps, Line of SKLAR Instruments, and top quality physicians MEDICAL BAGS.

DAYLESS MANUFACTURING COMPANY

Booth 13

Dayless Manufacturing Company will exhibit the amazing new KLEEN-RITE self-wringing sponge rubber mop and waxer for use in physician's offices and hospitals.

DESITIN CHEMICAL COMPANY

Booth 38

Desitin Chemical Company will exhibit the following products:

DESITIN OINTMENT: The pioneer in external cod liver oil therapy.

Indications: diaper rash, slow healing wounds, burns of all degrees, lacerations, hemorrhoids and fissures.

DESITIN POWDER: a unique, dainty medicinal powder saturated with cod liver oil.

DESITIN HEMORRHOIDAL SUPPOSITORIES with

COD LIVER OIL: coats ano-rectal area with soothing, lubricating cod liver oil, gives prompt relief of pain, allays itching.

DESITIN LOTION: the original cod liver oil lotion. soothing, protective, mildly astringent and healing, in non-specific dermatitis, pruritis, poison ivy, etc.

RECTAL DESITIN OINTMENT: A unique formula, providing rapid and effective relief in simple hemorrhoids, pruritus ani, fissures, etc. Does not contain narcotics, local anesthetics, styptics to mask any serious symptoms.

DOHO CHEMICAL CORPORATION

Booth 29

DOHO CHEMICAL CORPORATION is pleased to exhibit:

AURALGAN Ear medication in Otitis Media and removal of Cerumen.

OTOSMOSAN Effective, non-toxic Fungicidal and Bactericidal (gram negative-gram positive) in the suppurative and aural dermatomycotic ears.

RHINALGAN Nasal decongestant free from systemic or circulatory effect and equally safe to use on infants as well as the aged.

NEW LARYLGAN Soothing throat spray and gargle for infectious and non-infectious sore throat involvements.

Mallon Chemical Corporation, Subsidiary of the Doho Chemical Corporation, is also featuring:

RECTALGAN Liquid topical anesthesia, for relief of pain and discomfiture in hemorrhoids, pruritus and perineal suturing.

DERMOPLAST Aerosol freon propellent spray for fast relief of surface pain, itching, burns and abrasions. Also Obs. & Gyn. use.

EATON LABORATORIES

Booth 12

Published reports show that Furadantin® is one of the most effective and rapidly acting agents available at this time for the treatment of prostatitis and acute and chronic urinary tract infections.

Furadantin has specific affinity for the urinary tract, producing antibacterial concentration in 30 minutes. Time-consuming trial and error with less effective agents is eliminated.

It has been reported in the literature that "Tricofuron® Vaginal Suppositories and Powder are highly effective in the treatment of trichomonal vaginitis and the accompanying secondary bacterial infections.

Tricofuron affords relief of symptoms within a few days, and cures the majority of cases within one menstrual cycle.

EISELE & COMPANY

Booth 27

Eisele & Company will display their regular line of clinical thermometers, hypodermic syringes, both the regular type and the interchangeables, hypodermic needles, Eco bandages & specialty glassware.

ELI LILLY & COMPANY

Booths 31 and 32

You are cordially invited to visit the Lilly exhibit located in space Nos. 31 and 32. The display will contain information on recent therapeutic developments. Lilly sales people will be in attendance. They welcome your questions about Lilly products.

ENCYCLOPEDIA AMERICANA

Booth 63

Encyclopedia Americana invites you to inspect their 1957 edition—the ultimate in modern reference. No up-to-date school, college, university, or library is without it, as leading educators prefer and find it superior to all others. We are extremely proud of the fact that more than 1000 sets have been delivered to the U. S. Government for use in every major department. You will be cordially welcomed.

ENCYCLOPAEDIA BRITANNICA

Booth 69

E. FOUGERA & COMPANY

Booth 26

E. Fougera & Company, Inc. and Division, Varick Pharmacal Company Inc. cordially invite physicians to discuss with Professional Service

Representatives new preparations of importance to their every day practice. Descriptive literature and samples of all products will be available.

GEIGY PHARMACEUTICALS
Booth 54

The Geigy exhibit will feature PRELUDIN—the new chemically different appetite suppressant noted for its absence of side actions. Also on display will be BUTAZOLIDIN—potent non-hormonal antiarthritic; new STEROSAN Hydrocortisone Ointment — anti-inflammatory, bacteriostat and fungistat, and other well known Geigy products.

GREAT BOOKS OF THE WESTERN WORLD

In 54 volumes containing 443 works by 74 authors spanning Western thought from the Bible and Homer to the 20th Century. And including the key to a new method of reading—the world's first idea-index, the SYNTOPICON. The product of 400,000 man-hours of research by 100 scholars over a period of eight years.

H. J. HEINZ COMPANY
Booth 3

Heinz Baby Foods provide babies with the necessary nutrients for steady growth and sound bodies. These foods also make appetizing meals for older patients and convalescents.

Here are the newest Baby Foods. They are Heinz originals.

Strained Vegetables, Egg Noodles and Chicken
Strained Chicken Noodle Dinner
Strained Potatoes (White)
Junior Vegetables, Egg Noodles and Chicken
Junior Chicken
Junior Breakfast — Cereal, Eggs and Bacon
Junior Spaghetti, Tomato Sauce and Meat
High Protein Cereal

The Nutritional Date Book for physicians and literature for mothers' use are available.

JACKSON-MITCHELL PHARMACEUTICALS INC.
Booth 34

JACKSON-MITCHELL PHARMACEUTICALS are exhibiting MEYENBERG EVAPORATED GOAT MILK, MEYENBERG POWDERED GOAT MILK, the natural substitute milk in cow milk allergies, and HI-PRO, a high protein, low fat, powdered cow's milk.

Chilled, refreshing Goat Milk is being served so you can taste its pleasant flavor.

New Literature on all products is available.

LEDERLE LABORATORIES DIVISION AMERICAN CYANAMID COMPANY
Booth 6

You are cordially invited to visit the Lederle Booth where our Medical Representatives will be in attendance to provide the latest information and literature available on our line.

Featured will be Achromycin, Diamox, Vitamins, Pathilon, Varidase and many other of our dependable quality products.

THE LIEBEL FLARSHEIM COMPANY
Booth 10

The Liebel-Flarsheim Company cordially invites you to visit the booth in which their latest electromedical-electrosurgical equipment will be exhibited. We ask particularly that you stop and see the L-F BasalMeteR, the first automatic, self-calculating metabolism unit ever offered. Capable representatives will be on hand at all times.

J. B. LIPPINCOTT COMPANY
Booth 47

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

LOMA LINDA FOOD COMPANY
Booth 42

With the background of years of experience in perfecting a hypoallergenic milk powder, and also a newly developed concentrated liquid milk the protein of which is fully derived from the soybean and formulated with other essential additives to care for the needs of babies, growing children, and adults, the Loma Linda Food Company will be happy to welcome you to their exhibit. Attendants will be pleased to discuss the values of Soyalac powder and concentrated liquid. Samples of this flavorful product will be served at the exhibit.

S. E. MASSENGILL COMPANY
Booth 2

The S. E. Massengill Company extends its wishes for a most successful meeting and invites the convention to visit its booth and discuss Massengill Pharmaceutical products. The S. E. Massengill Company will feature Adrenosem Salicylate (The unique systemic hemostat), Homagenets (The only homogenized vitamins in solid form), Salcort (A safe effective anti-arthritic) and Massengill Powder.

MEAD JOHNSON & COMPANY
Booth 5

In the Mead Johnson booth, specially trained representatives will be ready to tell you about these product "families":

(1) The Mead Johnson Formula Products Family — including ready-to-use Lactum and Olac for routine infant feeding, as well as Dextri-Maltose.

(2) The Deca Vitamin Family — 3 convenient dosage forms for comprehensive vitamin protection of infants and children.

(3) The Colace family — providing a new approach in preventing and treating constipation by keeping stools soft for easy passage.

MEDCO PRODUCTS COMPANY
Booth 23

Featuring the MEDCO-SONLATOR. Provid-

ing a new concept in therapy by combining muscle stimulation and ultra-sound simultaneously through a SINGLE Three Way Sound Applicator.

The MEDCO-SONLATOR is a distinct advance in the effectiveness of physical therapy in your office or hospital. A few minutes spent in our booth should be of value to your practice.

THE MEDICAL PROTECTIVE COMPANY
Booth 64

MALPRACTICE PROPHYLAXIS. The Medical Protective Company's policyholders are in less jeopardy from malpractice litigation today than they have been for the past thirty years. "The Doctor and The Law", prepared by our Law Department, periodically informs policyholders how to reduce exposure to liability. Specialized Service makes our doctor safer.

MERCK & COMPANY INC.
Booths 40 and 41

"40 Plus" Exhibit. Using the theme "from forty to sixty . . . the future health of the aging and aged is largely determined," Merck dramatically presents physical systems influenced by vitamins, together with conditions common to the "40-Plus" Patient which are alleviated by vitamins. Graphics suggest to the physician ways in which vitamins can help him make his patients' "40-Plus" years "their most significant years."

MERCK SHARPE & DOHME
Booth 60

The Merck Sharp & Dohme exhibit presents highlights on steroid therapy featuring the newer adrenal cortical steroid preparations in endocrine disorders, collagen diseases, respiratory allergies, eye diseases and skin conditions.

Research developments in the field of antibacterial agents are of clinical significance.

Expertly trained personnel will be pleased to discuss advanced clinical reports on a new therapeutic agent which may be described as a "mood stabilizer".

V. MUELLER & COMPANY
Booth 22

The V. Mueller & Company (Chicago) exhibit will be comprehensive display of special and standard instruments for practically every surgical specialty. Our portable suction pump will be demonstrated, as will some of the newer instruments for specialty surgery.

NATIONAL LIVE STOCK AND MEAT BOARD
Booth 50

This exhibit features the recommended daily food intake for adequate teen-age nutrition, showing their needs for protein and other nutrients to be one-third to one-half more than that of their parents. There will be a display of nutrition education materials which may be secured upon request.

A. R. NECHIN COMPANY INC.
Booth 46

Among the items shown will be the new Jones AIR-BASAL. This is the newest concept in metabolism testing for it requires no oxygen tanks or capsules of any type. This unit measures the amount of oxygen the patient consumes from room air. Breathing ordinary room air is more natural to the patient and more accurate results are obtained. In addition to metabolism tests and vital capacity determinations, the AIR-BASAL is the only metabolism unit with which pulmonary function determinations can be made.

NORDMARK PHARMACEUTICAL LABS
Booth 39

New Iron Therapy — FERRONORD (TM) tablets, a brand of ferroglycine sulfate complex iron — will be featured. Extensive research has developed an aminoacetic complex of iron which supplies ferrous ions protected against oxidation in pH ranges of stomach and intestine. FERRONORD provides for:

1. Optimal absorption of ferrous iron.
2. Freedom from the side effects usually associated with iron therapy
3. Rapid increase of serum iron levels in days.
4. Correspondingly higher hemoglobin levels in days. So well tolerated, FERRONORD should be given on an empty stomach, or between meals, for optimal absorption.

NORTHERN ILLINOIS MEDICAL SERVICE INC.
Booth 37

Doctor, be sure to stop and pick up your "Blue Boutonniere from Blue Shield".

PARKE, DAVIS & COMPANY
Booth 65

Medical service members of our staff will be in attendance at our exhibit for consultation and discussion of various products of particular interest to members of the Association. Important specialties, such as Penicillin S.R., Benadryl, Chloromycetin, Ambodryl, Dilantin Suspension, Vitamins, Oxycel, Eldec, Milontin, Amphedase, Thrombin Topical, etc., will be featured. You are cordially invited to visit our exhibit.

PARKER, ALESHIRE & COMPANY
Booth 19

Administrators of the special sickness and accident plan for members of the Illinois State Medical Society.

Over $630,000 has been paid in claim benefits to insured members since the inception date, April 1, 1947. Your membership entitles you to participate in this successful plan.

You are cordially invited to visit our booth and ask our representatives for information about NEW — LONGER — NONCONFINING — PROTECTION recently made available. This exceptional income protection is a "MUST" for every complete disability program.

PFIZER LABORATORIES
Booth 55

The Pfizer exhibit spotlights its recent and original therapeutic concepts represented by Bona-

mine, Tyzine, Toclase, Cortril, STERANE and MODERIL, Pfizer's new alkaloid of rauwalfia. Special features, however, are SIGMAMYCIN, a combination of Matromycin and Tetracyn, and the newest advance in topical corticosteroid therapy, Magnacort, the first water soluble corticoid.

PROFESSIONAL MANAGEMENT

Booth 24

PM—the complete business service for the medical profession is celebrating 25 years of management for physicians and dentists exclusively.

Practicing physicians, residents and interns are invited to consult with us on the *Business Side of Medicine.*

Affiliated with Black & Skaggs Associates, Inc. of Battle Creek, Michigan.

PROFEXRAY INC.

Booth 18

Featuring the Profexray Rocket-100 Hand Tilt Combination unit. This is the only 100 MA machine on the market providing 100 MA exposures for ALL body regions (with very small focal spots), and offers automatic push button control, complete tube protection, electronic timing and separate tube stand.

PURDUE FREDERICK COMPANY

Booth 68

The Purdue Frederick Company will feature:

SENOKOT Tablets and Granules—new non-bulk, non-irritating constipation corrective acting selectively on the parasympathetic (Auerbach's) plexus in the large bowel, physiologically stimulating the neuromuscular defecatory reflex.

PRE-MENS—The multidimensional premenstrual tension therapy.

SOMATOVITE—clinically proven to promote weight gain, increase appetite and reduce hyperactivity and restlessness.

SIPPYPLEX—the modern comprehensive therapy for peptic ulcer.

COLPOTAB—a tested effective Tyrothricin trichomonacide, and

CHLOROGIENE—A HYGIENIC DOUCHE FORMULATION.

REED AND CARNRICK

Booth 43

You are cordially invited to visit the Reed & Carnrick exhibit, located in Booth No. 43. Our representatives in attendance will welcome the opportunity to give you information on: TARCORTIN — a synergistic combination of hydrocortisone 0.5% in Tarbonis, a greaseless, stainless cream containing 5.0% of a specially prepared coal tar extract. NEO-TARCORTIN — (Tarcortin and neomycin) indicated in eczemas complicated by infection. ANALEPTONE — elixir and tablet form, indicated for mental confusion, memory defects, antisocial attitudes, irritability, particularly in the aged.

R. J. REYNOLDS TOBACCO COMPANY

Booth 14

Welcome to the R. J. Reynolds Company Exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of CAMEL, WINSTON Filter, Menthol Fresh SALEM, or CAVALIER King Size Cigarettes.

A. H. ROBINS COMPANY INC.

Booth 58

The A. H. Robins Company exhibit spotlights DONNATAL. This "most prescribed" of all antispasmodic-sedatives is available not only in tablets, capsules and palatable Elixir, but also in long-acting Extentabs. Also featured: ALLBEE with C, capsules providing "saturation dosage" of B complex factors and ascorbic acid; DONNAGESIC EXTENTABS: ENTOZYME tablets; ROBALATE tablets and liquid.

J. B. ROERIG & COMPANY

Booth 62

J. B. ROERIG AND COMPANY, Booth 62, will feature ATARAX, the new "Peace of Mind" drug. It's an all new chemical and is considered an achievement in the quest for a better ataraxic. ATARAX is particularly indicated for the "more normal" person and brings relief from the common everyday anxieties and annoyances. It is quick acting yet requires low mg. dosage; does not disturb the mental acuity of the patient and has virtually no known side effects. Literature and samples available at the booth, which you and your friends are cordially invited to visit.

THE SANBORN COMPANY

Booth 30

Visitors at the Sanborn Company booth 30 will have full opportunity to see and have demonstrated our clinical diagnostic instruments such as the popular Viso-Cardiette and Metabulator.

In addition, there will be demonstrations and/or data available on the Vector System, Viso-Scope, and Transducers for pickup of pressure and other physiologic events; and on the Twin-Viso, Twin-Beam, and the "150" (and other) series of single and multi-channel direct-writing and photographic recording systems.

W. B. SAUNDERS COMANY

Booth 59

The complete Saunders line will be on display. Among some of the very newest of special interest to Clinicians—all published within the last nine months—are: Tracy: The Doctor as a Witness; Nadas: Pediatric Cardiology; Cecil & Conn: Specialties in General Practice; Beierwaltes: Radioisotopes: Friedberg: Diseases of the Heart; Conn: Current Therapy 1957; and a new edition of the red-backed Dictionary—Dorland's.

SCHERING CORPORATION

Booth 53

The Schering exhibit presents the Meti-steroid preparations METIMYD, METI-DERM, METRETON, SIGMAGEN, METICORTEN and METICORTELONE. Clinical and laboratory data demonstrating the advantages of these new steroids in topical and systemic therapy of allergic and in-

flammatory diseases are offered. New indications for the Meti-steroids are also presented.

JULIUS SCHMID INC.

Booth 44

An interesting and informative exhibit featuring RAMSES flexible cushioned Diaphragm; RAMSES Vaginal Jelly; VAGISEC jelly and liquid, two new products embodying "Carlendacide," the recent development of Carl Henry Davis, M.D., and C. G. Grand for vaginal trichomoniasis therapy; and XXXX (Fourex) Skin Condoms, RAMSES and SHEIK Rubber Condoms for the control of trichomonal re-infection.

G. D. SEARLE & CO.

Booth 52

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Nilevar, the new anabolic agent; Rolicton, the new safe, nonmercurial oral diuretic; Vallestril, the new synthetic estrogen with extremely low incidence of side reactions; Banthine and Pro-Banthine, the standards in anticholinergic therapy; and Dramamine, for the prevention and treatment of motion sickness and other nauseas.

7-UP DEVELOPERS ASSOCIATION

Booth 1

The organizations that bottle and deliver sparkling, crystal-clear 7-Up to the people of Illinois will be represented at Booth No. 1. They will be ready at all time to provide the cool, clean taste of 7-Up for thirsty conventioneers.

SHERMAN LABORATORIES

Booth 28

Severe asthmatic attacks are not merely relieved, but *terminated* in 10 to 20 minutes by Elixophyllin, given *orally*. In milder attacks, its speed has been described as "instantaneous."

Theophylline blood-levels were found in the therapeutic range in 15 minutes and 8 times higher than those of aminophylline or choline theophyllinate. Vital capacity increases were noted as soon as 5 minutes after administration. Pick up these data and reports at the Sherman booth.

SMITH, KLINE & FRENCH LABORATORIES

Booth 7

SKF's exhibit features 'Compazine', a dramatic tranquilizer and potent antiemetic, proven in over half a million patients, and remarkably free from drowsiness and other side effects.

We'll be on hand with the latest information and literature on 'Compazine' and other SKF products. Will you stop by and see us?

E. R. SQUIBB & SONS

Booth 35

E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the Medical Profession in new products or improvements in products already marketed.

STANDARD PROCESS LABORATORIES

Booth 49

The control of growth, health and vitality by protomorphogens. A protomorphogen is a cell secretion given off by all living cells, at all times in minute amounts, that promotes the synthesis of protein for cell repair and cell maintenance, after which it is absorbed by the cell. All living proteins carry a protomorphogen by which the protein is made specific in nature, specific in function and specific in causing organic reactions.

UNITED STATES TOBACCO COMPANY

Booth 36

The United States Tobacco Company will display its famous line of SANO tobacco products: Sano Cigarettes—both regular and King Size Filter Tip, Sano All-Havana Cigars and Sano Pipe Tobacco. . . all with less than 1% nicotine by weight. Sano meets the nicotine problem in the only effective way, by removing the nicotine from the tobacco, itself, before Sano tobacco products are made. Sano Cigarettes, cigars and pipe tobacco for good sense and good taste.

THE UPJOHN COMPANY

Booth 61

Members of the medical profession are invited to visit the Upjohn booth where members of The Upjohn Company professional detail staff are prepared to discuss subjects of mutual interest.

VITAMIN PRODUCTS COMPANY

Booth 49

See Standard Process Laboratories

WALLACE LABORATORIES

Booth 33

MILTOWN, the original meprobamate, will be featured at the Wallace Laboratories' exhibit, booth No. 33. It is a type of tranquilizer with muscle relaxing action. It is of value in treating anxiety-tension states, muscle spasm, sleeplessness due to worry and certain neurological disorders. It is of special interest that MILTOWN does not have autonomic side effects, is well tolerated and is essentially non-toxic.

WINTHROP LABORATORIES

Booth 11

LOTUSATE: 2 grains purple caplets, highly effective, well tolerated hypnotic providing 6 to 8 hours refreshing sleep at night. Also available in sedative doses. ½ grain yellow and ¾ grain salmon colored caplets.

LEVOPHED: the true vasoconstrictor hormone of the Adrenal Medulla, for the maintenance of blood pressure in shock and other acute hypotensive states.

THE ZEMMER COMPANY

Booth 48

Members of the Illinois State Medical Society are cordially invited to visit our exhibit which will be staffed by Milton H. Carrier and Robert A. Ehlers.

PROGRAM
of the
TWENTY-NINTH ANNUAL MEETING
of the
WOMAN'S AUXILIARY
ILLINOIS STATE MEDICAL SOCIETY

May 21, 22, 23, 1957
Hotel Sherman, Chicago

The wives of all Illinois physicians are cordially invited to attend the Convention.

Those responsible for the arrangements have been working diligently to develop their ideas and programs to make the 1957 Annual Meeting an especially fine one. Your presence and participation will insure the success of our meeting.

Tickets for social functions may be secured in advance by writing Mrs. Wendell Roller, ticket chairman, 309 South Main Street, Monmouth, or at the registration desk during Convention. Please register as soon as possible and obtain your badge and program.

REGISTRATION HOURS
Lobby Floor

Tuesday, May 21 ..... 8:30 a.m. to 4:00 p.m.
Wednesday, May 22 ... 8:30 a.m. to 4:00 p.m.

PRE-CONVENTION SCHEDULE

Tuesday, May 21

Pre-Convention Board Meeting .....
..... 9:30 a.m. to 10:30 a.m.
Reference Committee Meetings .....
... Mrs. Albert T. Kwedar, General Chairman
Reports of Officers and Directors .....
..... 10:30 a.m. to 11:00 a.m.
Reports of Councilors .....
..... 11:00 a.m. to 11:30 a.m.
Reports of Committees .....
..... 11:30 a.m. to 12:00 noon

CONVENTION PROGRAM

Tuesday, May 21
GEORGE BERNARD SHAW ROOM

1:00 p.m. Formal Opening of the Twenty-Ninth Annual Meeting
Mrs. Robert E. Dunlevy, President, presiding

Pledge to the Flag
Invocation
Pledge of Loyalty
Welcome .. Mrs. Richard E. Westland, Woman's Auxiliary to The Chicago Medical Society
Response .....
Mrs. William A. Herath, Woman's Auxiliary to the Rock Island County Medical Society
Report of Credentials and Registration Committee
..... Mrs. Henry Christiansen, Chairman
Reading of Convention Rules of Order .....
..... Mrs. George Hoffman, Parliamentarian
Adoption of Convention Program
Announcement of Reference Committee Appointments
Appointment of Committee on Courtesy and Resolutions
Appointment of Reading Committee
Appointment of Election Committee
Greetings from the Illinois State Medical Society
..... F. Garm Norbury, M.D., Chairman Advisory Committee to Woman's Auxiliary
Convention Announcements .....
... Mrs. S. M. Hubbard. Convention Chairman
Report of Joint Revisions Committee .....
..... Mrs. Lee N. Hamm, Chairman

TWILIGHT MEMORIAL SERVICE

Immediately following first delegate session

Conducting ..... Mrs. C. L. Bennett
Harpist ..... Miss Edna Michael
Soloist ..... Mrs. John S. Curtis

All members of the Convention are invited to the PUBLIC RELATIONS DINNER of the Illinois State Medical Society

6:00 o'clock George Bernard Shaw Room
Speaker ..... Mrs. Paul Jones. Director of Public Relations National Safety Council

BEAU BELLE BALL

Bal Tabarin ..... 9:30 p.m. to 12:30 a.m.
You will be the guests of the Illinois State Medical Society

Committee
Mrs. Harlan English, Mrs. Donald D. Spicer
Members of the Woman's Auxiliary to the Vermilion County Medical Society

WEDNESDAY, May 22

Hospitality Room
Continental Breakfast 8:00 a.m. to 9:15 a.m.
honoring
Mrs. G. Henry Mundt
Founder and First President of the Woman's Auxiliary to the Illinois State Medical Society
and
Mrs. James P. Simonds
Honorary Emeritus Publication Chairman of the Woman's Auxiliary to the American Medical Association
Committee in charge:
Mrs. Edwin S. Hamilton
District Councilors

SECOND GENERAL SESSION

George Bernard Shaw Room ..... 9:30 a.m.
The Auxiliary in Illinois .....
..... County Presidents reporting by districts
Job Opportunities Allied to Medicine .....
..... Mrs. S. Glidden Baldwin
LUNCHEON ..... 12:30 p.m.
Introduction of the Speaker .. Mrs. Robert Hart
"The Fifth Freedom" ..... Dr. Nicholas Nyaradi, Former Minister of Finance in Hungary
Committee
Mrs. W. R. Freeman, Mrs. Leo L. Roseman
Members of the Woman's Auxiliary to the Champaign County Medical Society

THIRD GENERAL SESSION

George Bernard Shaw Room ..... 2:30 p.m.
The Auxiliary in Illinois, continued .....
..... County Presidents reporting
Program emphasis .....
.... Mrs. Fred C. Endres, First Vice President
Reports of Reference Committees.

ANNUAL DINNER of the Illinois State Medical Society ..... 7:00 p.m.
The Ballroom

THURSDAY, May 23

FOURTH GENERAL SESSION

George Bernard Shaw Room ..... 9:30 a.m.
Report of Courtesy and Resolutions Committee..
..... Mrs. Warren W. Young, Chairman
Final report of Credentials and Registration Committee
Presentation of the Budget for 1957-58 .....
..... Mrs. Harlan English, Finance Chairman
Report of the Nominating Committee .....
..... Mrs. Carl E. Sibilsky, Chairman
Election of Officers
New Business
Convention Announcements

INSTALLATION LUNCHEON

Sheraton-Blackstone Hotel
The Mayfair Room 1:00 p.m.
honoring
Past Presidents of the Woman's Auxiliary to the Illinois State Medical Society
and
Mrs. Robert E. Dunlevy, Mrs. Nicholas G. Chester
Installation of Officers ..... Mrs. William Raim
Committee
Mrs. William B. Werner, Mrs. R. V. Grimmer
Members of the Woman's Auxiliary to the Tazewell County Medical Society

Hotel Sherman
Post Convention Board Meeting ..... 4:00 p.m.
Mrs. Nicholas G. Chester, Presiding

COMMITTEE CHAIRMEN

Not listed in the program

Election ..... Mrs. W. J. Wanninger
Exhibits ..... Mrs. James M. McDonnough
Favors ..... Mrs. M. G. Farinacci
Hospitality ..... Mrs. Joseph S. Lundholm
..... Mrs. Neal D. Crawford
Hospitality for Special Guests .....
..... Mrs. H. Close Hesseltine
House ..... Mrs. George L. Pastnack
Information ..... Mrs. Matthew E. Uznanski
..... Mrs. Richard E. Westland
Pages ..... Mrs. Leonard J. Houda
Press and Publicity ..... Mrs. John W. Koenig
Reading ..... Mrs. E. M. Egan
Tickets ..... Mrs. Wendell Roller
Timekeeper ..... Mrs. William Somerville

MEDICAL ECONOMICS



VA Medical Care

Caesar Portes, M.D., Chicago

SOME time ago I published an article in this Journal pertaining to Veteran Medical care. At that time I pointed out that only about five per cent of the patients in veterans hospitals were treated for service-connected disabilities. Ninety to 95 per cent of these patients were there for treatment and care of diseases of recent origin.

I pointed out at that time that no one has any objection to free medical care of veterans for service-connected disabilities, for tuberculosis, or neuropsychiatric disturbances. But we do object to VA Hospitals treating veterans for non-service connected disabilities. If the individual is indigent, he is entitled to admission to any of our city, county or state hospitals. Why should he be admitted to VA Hospitals? Yet, in spite of all the objections raised by the American Medical Association and other groups of organized medicine, the government continues to build large veteran hospitals and the doctors continue to give them medical care.

Recently a new problem arose as to veteran medical care. Two resolutions were adopted at the House of Delegates of the A.M.A. in November, 1956, concerning the present practice of the VA in providing medical care for veterans with non-service connected disabilities who are covered by Workmen's Compensation or have private medical insurance. It has been pointed out that the VA has rendered treatment to injured veteran workers who are entitled to medical care without charge under state or federal Workmen's Compensation laws.

Public Law No. 2, 73rd Congress, as amended, Section 6, provides: "That a veteran who is in need of hospitalization and is unable to defray the necessary expenses thereof shall be furnished necessary hospitalization in any Veterans Administration facility within the limitation existing in such facilities irrespective of whether disability was due to service. The statement under oath of the applicant on such form as may be prescribed by the Administrator shall be accepted as sufficient evidence of inability to defray the necessary expenses."

The question therefore arises whether Veteran hospitals should admit a compensation claimant for treatment of non-service connected disability when he is not personally liable for the cost of such medical care. The federal statute intended to limit hospitalization benefits in non-service connected cases to indigent veterans. But when the veteran is not required to pay for hospitalization because he is entitled to such benefits by law, then he should not be eligible for VA Medical Care. In fact, a Veteran hospital Administrator who provides such medical care may be violating the law.

Of course, the argument always is, what can we do with such powerful lobbyists and pressure groups as the VA? How can we control VA Medical Service?

My answer is, In only one way: If the medical profession will not support VA Hospitals and refuse to serve, the pressure groups would soon come to a logical and sensible realization.

Concomitant Medical Care

Walter C. Bornemeier, M.D., Chicago

THE need for medical attention by a physician, other than the surgeon, during serious surgical procedures has been adequately demonstrated. The payment for such care to a physician other than the surgeon has, however, not been adequately provided for. Occasionally, Blue Shield will make payment to the family physician, internist or pediatrician for assisting in the care of the patient during and after surgery, but no provision has ordinarily been made by contract for this service.

It should not be difficult to provide that in specific serious surgical procedures, a certain definite amount be paid for concomitant medical care. This should be a welcome solution to many of the problems that arise. Many complaints received by Grievance Committees arise because a second doctor has asked to be paid for service that the patient has not fully understood. Many complaints that come to insurance companies are based on the fact that when surgery is done, only the surgeon is paid.

If this type of coverage is to be provided, the impetus must come from the medical profession. The purchaser of coverage is usually interested mostly in getting protection against a surgical fee. The people who negotiate contracts for group coverage have been measuring coverage by the size of the surgical fees paid. The insurance companies evidently have felt that the surgical fees are easier to calculate, so have avoided the headaches of evaluating the medical care and particularly medical care concomitant with surgical procedures.

Perhaps some day concomitant medical care will be deemed necessary with all surgical procedures, but at present it should be well to provide this payment only for a specified group of procedures. These should include abdomino-perineal resection, partial or total gastrectomy, surgery of the pancreas, major blood vessels, heart, lung where an entire lobe or portion of a lobe is removed, surgery of the brain, nephrectomy, cystectomy, ureteral transplants, surgery of the spine, extensive dissection of the pelvis and major surgery on children. Diabetics and patients receiving cortisone require special care. A committee with representatives of all the doctors concerned could decide exactly what procedures to include. After this the American Medical Association should request all insurance companies writing medical-surgical coverage to provide this medical payment for concomitant medical care.

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Grass root research

Stored in the file cabinets and index records of 7,000 hospitals in this country, are answers to many medical mysteries, awaiting only the curious doctor willing to shape a key to fit the lock. Buried in these archives are records of millions of patients (some 200 million discharges in the past decade alone). What a wealth of material lies here for the one who will take the trouble to till the field. *Editorial. The Clinician as a Researcher. J. Med. Soc. New Jersey. Aug.* 1956.

THE P. R. PAGE

Edward A. Uzemack, Director of Public Relations

No Time for Complacency —

The public education problem of the medical profession is getting tougher year after year, as socialized medicine gets closer and closer. More and more health bills are being introduced in Congress and in state Legislatures.

In the 82nd Congress (1951-1952), 250 measures affecting medicine were introduced. This rose to 407 in the 83rd Congress (1953-1954). The 84th Congress (1955-1956) saw the presentation of 571 bills. This trend probably will continue in the current session.

This means that the medical profession must be more alert than ever or legislation inimicable to the public's welfare will slip through. It means more and more contact with representatives in Congress.

Some of the greatest activity in the health field has involved legislation widening the scope of medical care for federal beneficiaries. The latest of these is Medicare, voted last year for military dependents. Today, nearly one out of ever four persons is eligible to receive some degree of medical care at no cost to them. These include 22,599,000 veterans, 5,200,000 military personnel and their dependents, 5,100,000 public assistance recipients and 4,000,000 beneficiaries of the Compensation Act covering at-work injuries. Seven million other federal employees and their dependents will be eligible for health care if proposed legislation is enacted.

The health-spending of the federal government amounted to $2,268,826,576 in the 1956 fiscal year. In the current fiscal year, $2,558,719,168 will be spent, an increase of 12.8 per cent.

These figures are cited to show that socialized medicine is getting nearer and nearer. It is coming fast. There is no time for complacency.

"Trojan Horse" of Socialized Medicine —

Proponents of socialized medicine, defeated in their frontal attack via the Truman-Ewing plan for compulsory health insurance, are trying to gain their objectives through infiltration and flank attacks.

It is against these that the medical profession must guard itself, striking back with aggressive, mobilized efforts. The facts must be presented to the public on every possible occasion. An educated people is the best bulwark whenever an emergency arises.

The present session of Congress has been marked with countless so-called fringe measures which, in effect, would inject the federal government into medical education, health insurance, medical care for the dependents of military personnel, construction of private medical facilities, and a wide range of other medical activities, all of which should be left to states, local communities and local groups.

The effect of these "fringe" proposals in bringing us a step nearer to socialized medicine was pointed out by Dr. Louis M. Orr of Orlando,

Florida, chairman of the American Medical Association's Committee on Federal Medical Services in the Journal of the A.M.A.[1] A pamphlet reprint of this, entitled "The Trojan Horse," is now available from the A.M.A. It should be read by every physician so that he may be informed on the hidden dangers behind what may seem to be measures with good intentions.

Dr. Orr shows how the hospital and medical care program of the Veterans Administration could give the biggest nudge toward a program of medical care for all people. From $37 million in 1934, the VA budget for medical care has risen to $750 million in 1956, and the trend is still upward. This must be stopped, and stopped immediately.

Every physician must make it his individual responsibility to see that the public is informed of the dangers, and do so immediately. Delay can mean the end of our private system of health care.

Write to the A.M.A. now for a copy of "The Trojan Horse." Upon its receipt, read it carefully. Have it in your waiting room for your patients to read.

1. Orr, Louis M.: To Socialized Machine and Socialism by Way of Veterans Administration, JAMA 162:840 (Oct. 27, '56).

Public Relations Gleanings —

The Chicago Hospital Council, 105 West Adams Street, Chicago 3, has issued a six-page "Guide to Ethical Hospital—Press—TV—Radio Relationships." It sets forth the rights and requirements of newsmen regarding stories originating in hospitals, and was developed by a joint committee of hospital representatives and newsmen. The Chicago Medical Society has approved the principles of the guide.

Members of the Shawnee County Medical Society, Topeka, Kan., approved a $5 assessment this year as the society's share of a local Science Fair expenses.

The Bulletin of the San Diego County Medical Society and the Bulletin of the Utica (N.Y.) Academy of Medicine have set aside special sections to honor physicians for participation in community affairs. This is well-deserved recognition of good public relations.

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Ascending infection

Most authors agree that bacteria, chiefly fecal flora, may enter the bladder after contamination of the urethra. The greater incidence of urinary tract infection in female children is explained on this basis. Bacteria migrate out of the bladder into the ureters, and from there to the kidneys as a result of vesicoureteral or ureteral reflux. Vesicoureteral reflux may be the consequence of inflammatory changes in the intravesical portion of the ureter, with conversion of the lower end of the normally easily compressible ureter into a rigid or semi-rigid tube. Furthermore, obstruction of the lower urinary tract due to contracture of the vesical outlet, prostatic hypertrophy, congenital valves of the posterior urethra, urethral stricture, or spastic neuromuscular disease, may cause sufficient intracystie back pressure to injure or destroy the mechanism of the ureterovesical valve; secondary infection may aggravate or accelerate the ureterovesical valve injury. Ultimately, vesical contraction directly forces infected urine in the bladder up the ureter. Ureterovesical reflux has been demonstrated by the technic of the delayed cystogram. *Harry A. Derow, M.D. Management of Pyelonephritis. New England J. Med. Aug.* 16, 1956.

CORRESPONDENCE



Clinics for crippled children listed for May

Twenty-four clinics for Illinois' physically handicapped children have been scheduled for May in the University of Illinois, Division of Services for Crippled Children. The Division will count 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing service. There will be 3 special clinics for children with cardiac conditions, 1 for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

The May clinics are:

May 1 - Hinsdale, Hinsdale Sanitarium
May 2 - Sterling - High School Field House
May 2 - Monticello - Lincoln School
May 7 - Casey, Casey High School
May 7 - Macomb, Marietta Phelps Hospital
May 8 - Fairfield, Fairfield Memorial Hospital
May 8 - Joliet, Will County T.B. Sanitarium
May 9 - DuQuoin, Marshall-Browning Hospital
May 9 - Springfield, St. John's Hospital
May 10 - Chicago Heights (Cardiac), St. James Hospital
May 14 - East St. Louis, St. Mary's Hospital
May 14 - Peoria, Children's Hospital (St. Francis)
May 14 - Pittsfield, Illini Community Hospital
May 15 - Elmhurst (Cardiac), Memorial Hospital of Dupage County
May 15 - Evergreen Park, Little Company of Mary Hospital
May 16 - Litchfield, Madison Park School
May 16 - Rockford, St. Anthony's Hospital
May 21 - Alton, Memorial Hospital
May 22 - Aurora, Copley Memorial Hospital
May 22 - Springfield (Cerebral Palsy), Memorial Hospital
May 23 - Decatur, Decatur-Macon County Hospital
May 24 - Chicago Heights (Cardiac), St. James Hospital
May 28 - Effingham (Rheumatic Fever), St. Anthony Hospital
May 28 - Peoria, Children's Hospital (St. Francis)

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical and corrective and other services and facilities for diagnosis, hospitalization, and after-care for children who are crippled or who are suffering from conditions which may lead to crippling.

Change in home town care for veterans plan

In accordance with established policy, fee basis medical services for veterans with service connected disabilities are authorized customarily in monthly cycles. On requests from fee basis physicians to continue treatments, which are subject to approval by the VA, services are re-authorized for a 30 day period.

New procedures have recently been established by the VA for certain selected VA out-patients who require professional services for their service connected disabilities on a recurring basis for a period of many months. These cases will be designated as "Category Long-Term (LT) Out-Patients", and the VA station of jurisdiction may authorize services extending over a period of many months when:

(1) Immediate supervision is exercised by a participating physician who has agreed to treat eligible veterans in accordance with the contract between the Illinois State Medical Society and the VA.

(2) Treatment will be required over a protracted period of time.

(3) The veteran has demonstrated his acceptance of treatment services made available by the government by keeping appointments regulary unless there were valid reasons to the contrary.

(4) Professional and ancillary services required by the veteran on a recurring basis can be forecast within reasonable limits.

Records relating to eligible veterans presently authorized fee basis care will be screened to segregate those cases in which all of the above criteria are met, and as soon as feasible, those fulfilling these criteria will be included in the group of Long-Term Out-Patients as applications for outpatient treatment are processed. Beneficiaries with service connected diabetes, chronic chest conditions, psychoneurosis, chronic gastro-intestinal and vascular diseases, certain neurological disabilities and other chronically ill patients will be considered for inclusion in the category of Long-Term Out-Patients. Final responsibility for assigning individual patients to this special category rests with VA authorities.

The success of this plan of operation for long-term cases will depend in large measure upon the effectiveness with which the participating physicians co-operate with the VA and understand their part of the program. It is essential, as in all fee basis service, that the physician remember that outpatient care may be furnished for only the disability for which the veteran is rated service connected by the VA. Treatment must be appropriate to the type of disability for which services have been authorized by the VA, and the frequency of such treatment will be based upon the actual needs of the veteran.

An estimate of recurring monthly services, including X-ray and clinical laboratory examinations, and the anticipated duration of the course of therapy will be secured as required from the participating physician. When the proposed monthly base has been reviewed and approved by the VA, only one authorization will be issued on VA standardized forms to the fee basis physician. The inclusive dates showing the period during which the authorization is valid will be recorded on the form. Entries will be made on the physician's copy to indicate the approved monthly treatment base and related fees as:

Estimated Monthly Services

Item 0014 - 3 office visits @$2.50	$7.50
Item 0003 - 1 urinalysis @ $2.00 (Routine, Chem. & Micro.)	2.00
TOTAL	$9.50

or:

Item 0056 - 3 office visits @ $3.00 (specialist)	$ 9.00
Item 0615 - Blood sugar	3.00
TOTAL	$12.00

Billings will be submitted by fee basis physicians promptly at the end of each month for services rendered Long-Term Out-Patients. Itemized statements of account will be prepared on the physician's own letterhead and will bear the following certification over the personal signature of the physician:

> "This is to certify that fees charged are reasonable and not in excess of fees charged the general public for similar services in this locality."

In the event that invoices are received for unanticipated medical services, submitted by the physician or a third party, they may or may not be approved. It is the responsibility of the VA

authorities to determine whether or not services for which payment is claimed were rendered during the period covered by the authorization and that they were reasonably necessary to provide approved treatment for the veteran's service connected disability. If for any reason treatment is discontinued, the physician should notify the VA field station without delay.

Prior to July 1, the beginning of each fiscal year, all Category Long-Term Out-Patients will be evaluated carefully by the VA to determine whether or not this special status should be maintained in the ensuing fiscal year and the monthly treatment base continued at the same or a modified level. The one-time authorization technique will then be applied to be effective after July 1 in all cases in which the prescribed criteria are met. The authorization form received by the physician will indicate the period during which the authorization is valid, whether it be for a few months or all year. Under no circumstances will individual authorization for long-term cases extend beyond the close of a fiscal year on June 30.

Reports of treatment will be prepared by fee basis physicians on Category Long-Term cases on standardized VA forms which will be sent to the physician. These treatment reports must be submitted every three months and it is stressed that they must be more complete and meaningful than has been generally the case in the past. They should present, as applicable, an adequate history, examination findings, diagnosis, detailed description of the treatment regimen including medications prescribed, dosage and frequency, results of laboratory and X-ray studies and prognosis.

The providing of outpatient medical services to certain VA beneficiaries requiring long-term fee basis care, according to new procedures, should provide better service to veterans, reduce professional effort, cut down paper work, and improve working relationship with physicians participating in the VA fee basis program.

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With adequate and proper present-day management of tuberculosis, pregnancy should not be considered as a complication nor should it be looked upon with concern as a cause of progression of the disease. Loren M. Rosenbach, M.D., Columbus R. Gangemi, M.D., J.A.M.A., July, 1956.

Beau belle ball

The Woman's Auxiliary to the Illinois State Medical Society is proud to hostess the Beau Belle Ball which will follow the Public Relations Dinner on Tuesday May the twenty first. The time: about 9:30 P.M.; the place: The Bal Tabarin of the Hotel Sherman; the object — fun and friendliness.

Benny Sharp and his Orchestra, featured with Ed Sullivan and the "Toast of the Town" television show will provide the music. There will be dancing, entertainment, and much merriment.

All physicians, physicians' wives, and exhibitors are invited to this party as guests of the Illinois State Medical Society. There will be no charge — just ask for your ticket when you register as a member of the annual meeting.

Don your favorite party clothes, attend the Public Relations Dinner, come to the Beau Belle Ball. YOU are invited.

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Sangamon county society television series

1. March 3, — "Quick Watson, the Needle"! Concerning Vaccines Especially Polio
2. March 10, — "The Hot War On Germs". Antibiotics
3. March 17, — "Your Spots are Showing". Contagious Diseases
4. March 24, — "Watch that Streptococcus"! Rheumatic Fever
5. March 31, — "Hearing Things" About Ears and Hearing
6. April 7, — "Does it Hurt Much?" Abdominal Pain
7. April 14, — "Quit Your Itching" Diseases of the Skin
8. April 21, — "Let's See Now" Concerning Eyes and Vision
9. April 28, — "Pardon My Neurosis" Mental Health
10. May 12, — "For a Little Stranger" Prenatal Care
11. May 19, — "More than Just a Weed" Concerning Allergies
12. May 26, — "What's New about Your Kidney" About Genitourinary Diseases
13. June 2, — "It Could Happen to You" Fractures and Accidents

The above television series sponsored by the Sangamon County Medical Society, started

early in March and will be conducted weekly as a three man panel, with a moderator from the studio staff. It is called "It's Worth Your Life", and is shown each Sunday afternoon at 4:30 o'clock.

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The American Goiter Association

The 1957 annual meeting of the American Goiter Association will be held in the Hotel Statler, New York City, May 28-30, 1957.

The program for the three days meeting will consist of papers and discussions dealing with the physiology and diseases of the thyroid gland.

More details and the program may be procured by writing to John C. McClintock, M.D., Secretary, American Goiter Society, 149½ Washington Avenue, Albany 10, New York.

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Fifth class date announced for army's unusual military medicine course

Starting date will be September 3, 1957 for the fifth class of Military Medicine and Allied Sciences presented annually by the Walter Reed Army Institute of Research to develop highly qualified professional leadership at Army medical research, teaching and treatment centers, Maj. Gen. Silas B. Hays, Surgeon General of the Army, announced today.

Fifteen medical officers who have completed formal residency training in a specialty will be selected for the nine-month course, said to have no counterpart in the United States. No attempt will be made to cover clinical subjects in a textbook fashion or to review generally available textbook data. Basic mechanisms are to be studied, recent advances in the sciences examined and correlation made between the various areas of science.

The students will be guided into a broad pattern of many subjects by a resident and visiting faculty of Army, Navy, Public Health and other governmental authorities and by lecturers from many of America's leading universities and from Europe.

Considerable time will be spent on the medical aspects of radiation, radioisotopes, nuclear warfare, treatment of mass casualties, chemical and biological warfare agents and certain global epidemiological concepts of particular importance to military professional personnel.

Approximately half of the time in the course will be devoted to individual research projects which afford the students an opportunity to apply theoretical material to a practical purpose. A thesis must be completed and accepted before graduation on June 20, 1958.

Proposed legislation making it possible for such graduates to be awarded a Master's degree in Science by the Walter Reed Army Institute of Research is being processed under the Federal policy governing the granting of academic degrees by Federal institutions.

"The increasing size and mobility of modern armies, the complexities of potential weapon effects and the world-wide nature of our responsibilities as a nation are placing more and more demands on the medical services of our Army," commented General Hays in making known the date of the 1957-58 course.

"This means the individual medical officer must be prepared for any military medical situation anywhere on the globe. At the same time he must maintain the highest professional standards in his medical specialty. We think this course combines lectures, conferences and laboratory sessions useful to all specialties, to those officers concerned with research and to those planning an entirely clinical career."

A highlight of the class commencements is the awarding of the Hoff Medal, established to commemorate Col. A. H. Hoff and given to the students attaining the highest class proficiency. The medal was founded by Col. John Van Rensselaer Hoff in 1897 and first awarded in 1902.

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AT THE EDITOR'S DESK



SECOND Lt. John L. Charlton, Jr. is the first chiropodist to be commissioned in the Army Medical Service Corps. In his office at Walter Reed Army Hospital, he will treat bunions, corns, and fungal infections and perform minor foot and toe surgery. In addition, he will advise patients on the care of the feet, examine footwear, and prescribe and fabricate special orthopedic appliances.

Congress is working on a $6.7 million plan to improve career opportunities for nurses and medical specialists of the Army, Navy, and Air Force. This means promotions for more than 1,800 Regular nurses.

The old horse-drawn caisson, which has been used in military funerals at Arlington National Cemetery for 92 years, will be replaced by motorized hearses. The two caissons will be sent to the museum at West Point and the 17 horses will be offered to other services.

Passavant Memorial Hospital has installed Motorola Pocket Radio Pagers. The attending men carry the gadget when making rounds and communicate with the telephone operator as soon as they hear a two to three second "beep." The set is a miniature walkie-talkie, with the telephone operator doing all the talking.

Dr. Russell L. Cecil offered the happy suggestion that a cocktail before dinner goes a long way toward relieving the pain of arthritis. Dr. Cecil, now the medical director of the Arthritis and Rheumatism Foundation, is a long- standing believer in the therapeutic usefulness of alcohol in moderation, according to a news release.

New Drugs: Parke-Davis has put out Celontin, a new anticonvulsant for psychomotor seizures. Pacatal, a new German ataractic drug, is announced by Warner-Chilcott. It is said to be useful in paranoid and catatonic schizophrenia, and involutional states, as well as in the anxiety, querulousness, and tension of the senile patient. Bendectin is being marketed by Merrell for treatment of the nausea and vomiting of pregnancy. This product has stiff competition. Lilly is offering a new and safer rabies vaccine, produced in embryonated duck eggs. It is free of the paralytic factor and the antibodies appear in the patient's blood within 10 days after the initial injection. Dalacin is a new Upjohn antibiotic that shows promise in tuberculosis. It is active against a wide variety of bacteria but its activity against the tuberculosis organism is particularly striking. Laboratory tests show it to be ten times as active as streptomycin and about 100 times as active as PAS.

The Food and Drug Administration published a proposed regulation establishing new minimum daily requirements for two of the B vitamins. The requirement for niacin is set at 10 milligrams. The ruling would reduce the riboflavin requirement from two milligrams to one.

NEWS of the STATE



ADAMS

Society News.—Speakers before the Adams County Medical Society in Quincy recently were Drs. Andrew B. Jones, associate professor emeritus of clinical neurology, Washington University School of Medicine, on "A Few Remarks about Man and some Drugs and Methods of Treatment"; Arthur E. Perley, Waterloo, Iowa, on cancer of the breast, and Joseph F. Montague, New York, colitis.

Personal.—Drs. L. A. Stefan and Gene Ahern, both of Quincy, have been elected into membership of the Adams County Medical Society.

Business Actions.—At a recent meeting of the Adams County Medical Society, it approved the request of the Adams County Tuberculosis Association to endorse a yearly examination to rule out the presence of tuberculosis among school personnel. It disapproved a proposed plan whereby persons who receive public aid would be paid direct by the government for all medical service secured, paying in turn the physician. This would be in lieu of the present plan whereby the physician is paid directly by the government for medical service rendered a patient receiving public aid, according to a release from the society.

ALEXANDER

New Health Officer.—Dr. Huston J. Banton, formerly regional director of the American Red Cross with headquarters in Massachusetts, was recently named health officer of the Alexander-Pulaski Bi-County Health Department. Dr. Banton is a native of Illinois, receiving his degree in medicine from the University of Illinois College of Medicine.

COOK

New Fellowship.—Dr. Kurt Aterman, senior lecturer in the department of anatomy at the Medical School of Birmingham, England, has been appointed the first May Cave Willett research postdoctoral fellow in Lying-in Hospital of the University of Chicago. The appointment, supported through a grant of $100,000 by Howard Willett, Sr., in honor of his wife, is one of the first made to initiate Lying-in Hospital's new type research program in the physiology of reproduction. Achievements of medical science in reducing infant and maternal mortality have been so notable that the hospital is now able to turn to fundamental biological problems. Dr. Aterman is undertaking a study of histological and chemical changes in the cells of the endometrium, the lining of the ovaries, using electronmicroscopy. It is suspected that defects in the mechanism of the endometrium are responsible for miscarriage and his research is a basic approach to the problem.

Personal.—Dr. Stephen Manheimer has resigned as director of Mount Sinai Hospital, a position he held for twenty years. He will continue as consultant. Nathan W. Helman, associate director, will assume most of the duties of Dr. Manheimer, but with the new title of administrative director.—Dr. James P. Greenhill has been awarded the Croix de Chevalier of the Legion of Honor of France.—Dr. Morris Fishbein, former Editor of The Journal of the American Medical Association, on March 8 was presented with an honorary degree of doctor of laws by Florida Southern College.

Personal.—Dr. Maxwell P. Borovsky has been elected chief of staff of Cook County Children's Hospital.—Dr. Eugene F. Lutterbeck, professor of radiology at Cook County Graduate School of Medicine, has accepted an invitation for a four week medical study tour of the Federal Republic and West Berlin. He will give a series of lectures on

various phases of radiation therapy and the practical use of radioisotopes at the Universities of Bonn, Frankfurt au Main, Munich, West Berlin and Bern, Switzerland.—Mr. William X. Kaplan has been named director of the department of public relations at the Chicago Medical School.

Faculty Appointments.—The Chicago Medical School announces the following appointments: Drs. George Podzamsky, clinical assistant in medicine; Norman A. Wien, instructor in medicine; Burton M. Jacobson, clinical assistant in medicine, and Alex Kaplan, assistant professor of clinical pathology.

LAKE

New Members.—Dr. Nathan Tolwinsky has been accepted into membership of the Lake County Medical Society, on a transfer from the Chicago Medical Society. Drs. Robert J. Stein and Monte Jay Meldman, Waukegan and Highland Park, respectively, have also been accepted into membership in the society.

Society News.—The Lake County Medical Society was the guest of Mr. Gordon Fletcher, National Accounts Service, Inc., at a social hour preceding their regular meeting, February 12, at the Swedish Glee Club, Waukegan. The society was addressed by Mr. A. D. Swarztrauber, accountant, on "Income and Estate Tax Planning."

PEORIA

Society News.—"Poliomyelitis" was discussed by Dr. Alex Steigman, professor of pediatrics, University of Louisville School of Medicine, before the Peoria Medical Society at the University Club, March 19,

Walter Baer Honored.—A testimonial dinner was held, February 14, to honor Dr. Walter Baer for his many contributions to mental health. Sponsored by the Peoria Mental Health Society, of which Dr. Baer was a founder, the dinner was attended by members of the local county medical society and civic groups. Dr. Baer was credited with founding the Mental Health Clinic in Peoria in 1940. Newspapers reported that it was under his administration as head of the Peoria State Hospital that the first School of Psychiatric Nursing in Illinois was founded at the hospital. He also planned and helped establish the Grace Abbott Children's Center, the first hospital devoted exclusively to psychotic children at Peoria State Hospital. Principal speaker at the dinner was Dr. Jack R. Ewalt, director of the U. S. Congress' Joint Commission on Mental Illness and Health and commissioner of the Massachusetts Department of Mental Health. Also present was Mrs. Edward Quayle, president of the Illinois Society for Mental Health and author of "The Snake Pit." Dr. Baer was presented with a reprint of a rare book "Schizophrenia, 1567," flown to Peoria for the occasion from London, England. Presentation was made by Gerald M. O'Connor, president of the Peoria Mental Health Society.

ST. CLAIR

Society News.—W. R. Konneker, Ph.D., consulting physicist, addressed the St. Clair County Medical Society at Augustine's Restaurant, Belleville, on "Radioactive Isotopes in Medicine."

Personal.—Dr. Dale Rosenberg, Belleville, has been accepted into membership of the St. Clair County Medical Society.

SANGAMON

Society News.—"The Newer Antibiotics—Their Use and Abuse" was the subject of Dr. John C. Herweg before the Sangamon County Medical Society, February 7. Dr. Herweg is assistant dean of Washington University Medical School.

Personal.—Walter L. Oblinger, Springfield, Associate Counsel, Illinois State Medical Society, appeared on the programs of the Woman's Auxiliary to the Champaign County Medical Society, March 14; Secretaries' Conference, Springfield, March 24, and a joint meeting of the Lake County Medical Society and its Woman's Auxiliary, April 4. Mr. Oblinger discussed Current Legislative Problems at the three meetings.

VERMILION

Society News.—The Vermilion County Medical Society at the Danville Ministerial Association met jointly at the Hotel Wolford, Danville, March 5. Rev. Granger Westberg, University of Chicago School of Medicine and Federated Theological Faculty, addressed the meeting.

WINNEBAGO

New Members.—Dr. Arthur E. Sulek has transferred from the Medical Society of Milwaukee County into the Winnebago County Medical Society. On January 1 he became the Medical Director at the National Lock Company in Rockford. Dr. Miller L. Henderson, staff neurologist at the Veterans Administration, Hines, Ill., has been accepted into membership of the society. He is a transfer member from the Chicago Medical Society, and is associated with the Canfield Clinic, 326 West Jefferson Street, Rockford.

GENERAL

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:

Maurice M. Hoeltgen, Chicago, South Shore Temple, March 8, on Does Society Have a Responsibility for the Health of the Individual.

Paul K. Anthony, clinical associate in pediatrics, Stritch School of Medicine of Loyola University, Evergreen Park Christian School, April 2, on School Health.

Lawrence Breslow, clinical assistant professor of pediatrics, University of Illinois College of Medicine, Bateman Private School, April 3, on School Health.

Elfriede Horst, Des Plaines, American Legion Auxiliary, in Morton Grove, April 9, on Parent-Child Relationship.

James C. Havranek, Berwyn, assistant clinical professor of medicine, Stritch School of Medicine of Loyola University, Faculty Women and wives of faculty, Elmhurst College in Elmhurst, April 10, on What's New in Medicine.

James W. Marshall, member of Monmouth Hospital, Monmouth, Avon (Ill.) Community Unit School District 176, April 10, on Understanding the Adolescent.

Howard S. Traisman, clinical assistant in pediatrics, Northwestern University Medical School, McPherson School Parent Education Class, April 16, on Your Child's Health.

George H. Klumpner, member of the staff of the Institute for Juvenile Research, Woman's Auxiliary to the Northwest Branch of the Chicago Medical Society, April 23, on Psychiatry and Mental Health.

George P. Vlasis, member of the staff, Chicago Maternity Center, Peck School Parent-Teacher Association, May 8, on Rules for Good Health.

Lectures Arranged Through the Committee on Postgraduate Medical Education and Scientific Service:

William R. Best, assistant professor of medicine, University of Illinois College of Medicine, Bureau County Medical Society in Spring Valley, March 12, on Diagnosis and Treatment of Blood Dyscrasias.

Leon J. Unger, associate professor of medicine, Northwestern University Medical School, La Salle County Medical Society in Ottawa, March 14, on Allergy.

J. Henry Heinen, Jr., clinical instructor in orthopedic surgery, University of Illinois College of Medicine, Lee-Whiteside County Medical Societies in Dixon, March 21, on Injuries About the Knee.

Donald I. Bell, Evanston, instructor in medicine, Northwestern University Medical School, La Salle County Medical Society in La Salle, April 11, on Diabetes—Diet and Insulin Regulation.

Walter C. Bornemeier and Frederick W. Slobe, both members of the Medical Economics Committee of the Illinois State Medical Society, Whiteside-Lee County Medical Societies in Rock Falls, April 18, on The Pro and Con of Social Security.

John T. Grayhack, assistant professor of urology and director of the Kretschmer Memorial Laboratory, Northwestern University Medical School, Bureau County Medical Society in Princeton, May 14, on Recent Advances in Urology.

Postgraduate Conferences.—On March 21, a Postgraduate Conference was held at the American Legion Club, Murphysboro, under the auspices of the Committee on Postgraduate Medical Education and Scientific Service of the Illinois State Medical Society in cooperation with the faculty of St. Luke's Hospital, Chicago. With Dr. Paul S. Baur, Cario, member of the state society committee from the Tenth District presiding, the Jackson County Medical Society acted as host.

Speakers were Walter F. Hoeppner, attending physician, on "Arthritis: Practical Indications for Cortisone in Joint Pain"; Foster L. McMillan, attending surgeon, on 'Newer Concepts in the Management of Intestinal Obstructions"; Richard B. Capps, attending physician, on "Differential Diagnosis of Jaundice"; William F. Geittman, attending obstetrician and gynecologist, "Hemmorhage: Accuracy and Feasibility of Measuring Amounts of Blood Loss and Its Significance During the Stages of Labor", and George W. Scupham, attending physician, "Rheumatic Fever—Streptococcal Infections". Discussants were Drs. Charles E. Fildes, James A. Weatherly, Eli L. Borkon, Andrew R. Esposito, and Homer H. Hanson.

A fellowship hour preceded the dinner, at which Dr. John S. Lewis, Carbondale, presided as president of the Jackson County Medical Society. Speakers were Mr. Thomas A. Hendricks, Field Director, American Medical Association, on "Behold the Turtle!" and Dr. Willard W. Fullerton, Sparta, Councilor for the Tenth District, on "Current Medical Problems Today."

A similar conference was held at the Benwood Hotel, Effingham, March 14, in cooperation with the faculty of Stritch School of Medicine of Loyola University, and with the Effingham County Medical Society acting as host.

At the afternoon session, held at St. Anthony Memorial Hospital, Dr. F. W. Siegert, Pana, member of the state medical society committee from the Seventh District, presided. Dr. George F. O'Brien, chairman of the department of medicine at Stritch, served as moderator of the program devoted to the "Care of Highway Accident Victims." Speakers were Drs. George W. Ferenzi, clinical assistant in medicine; John J. Brosnan, clinical associate in surgery; Robert L. Schmitz, associate clinical professor of surgery; Joseph T. Coyle, clinical associate in bone and joint surgery; James J. Duffy, clinical associate in surgery, and Frank Pirrucello, clinical instructor in surgery. Discussants were Drs. Peter Rumore, William Sargent and Henry Thompson. Dr. Henry Poteruchs, president of the Effingham County Medical Society, presided at the evening session which was devoted to a film presentation on "The Medical Witness." Mr. Bernard Hirsh of the Law Department of the American Medical Association served as moderators and participants in the question and answer session were Mr. Frank H. Schneiderjon, Mr. Paul Taylor, Dr. Wallace W. Gist and Dr. Glenn M. Marshall all of Effingham. Dr. Arthur F. Goodyear, Decatur, Councilor of the Seventh District, spoke on "The Medicare Program."

Another conference was held at the Faust Hotel, Rockford, March 13, in cooperation with the faculty of Cook County Graduate School of Medicine and with the Winnebago County Medical Society acting as host. Dr. J. Howard Maloney, Rockford, member of the State medical society committee from the First District, presided at the afternoon session on "Care

of Highway Accident Victims." Participants were Drs. Anthony J. Nicosia, associate professor of surgery; Joseph P. Cascino, professor of neurosurgery, and Donald S. Miller, professor of orthopedic surgery. Discussants were Drs. Alfred C. Meyer, Theodore J. Lang, and Donald W. Lyddon. Dr. C. B. McIntosh, Rockford, president of the Winnebago County Medical Society, presided at the dinner session. Speaker was Mr. Arthur J. Snider, Science Writer, Chicago Daily News, on "Medicine Meets the Press".

DEATHS

Herbert R. Atherton*, Kenilworth, who graduated at Washington University School of Medicine, St. Louis, in 1936, died February 20, aged 48. He was medical director for Swift and Company.

Lyle L. Bake*, Wood River, who graduated at the University of Tennessee College of Medicine, Memphis, in 1927, died in November, aged 61.

Axel H. Christensen, retired, Geneva, who graduated at the Hahnemann Medical College and Hospital, Chicago, in 1897, died March 6, aged 87.

Oscar S. Dailey*, retired, Port Byron, who graduated at the College of Physicians and Surgeons, Keokuk, in 1895, died January 31, aged 89.

David N. Deering*, Antioch, who graduated at the University of Nebraska College of Medicine, Omaha, in 1925, died February 18, aged 57.

Frank Nathaniel Evans*, retired, Springfield, who graduated at the University of Michigan Department of Medicine and Surgery, Ann Arbor, in 1911, died December 4, aged 68.

Townsend B. Friedman*, Chicago, who graduated at the University of Chicago School of Medicine in 1933, died March 6, aged 51. He was chairman of the departments of allergy at Michael Reese and Children's Memorial Hospitals.

Simon D. Gideon*, Chicago, who graduated at Ludwig-Maximilians-Universität Medizinische Fakultät, München, Bavaria, Germany, in 1923, died December 15, aged 59. He was a fellow of the International College of Surgeons and the American College of Gynecology and Obstetrics.

George Gomori*, Palo Alto, California, formerly of Chicago, who graduated at Magyar Királyi Pázmany Petrus Tudományegyetem Orvosi Fakultasa, Budapest, in 1928, died February 28, aged 52. He was formerly professor of medicine at the University of Chicago School of Medicine.

Willis F. Holsteen*, retired, Danville, who graduated at the Jenner Medical College in 1898, died December 23, aged 86.

William J. Jones*, Mt. Vernon, who graduated at Creighton University College of Medicine, Omaha, in 1946, died February 12, aged 33.

Elwood Almon Kingston*, Lockport, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1903, died November 20, aged 80. He was a member of the staffs of the St. Joseph's and Silver Cross Hospitals in Joliet.

Eugene P. Wright, retired, North Miami Beach, Florida, formerly of Chicago, who graduated at Jenner Medical College in 1909, died December 3, aged 78.

*Indicates a Member of the Illinois State Medical Society.

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(*Continued on page* 56)

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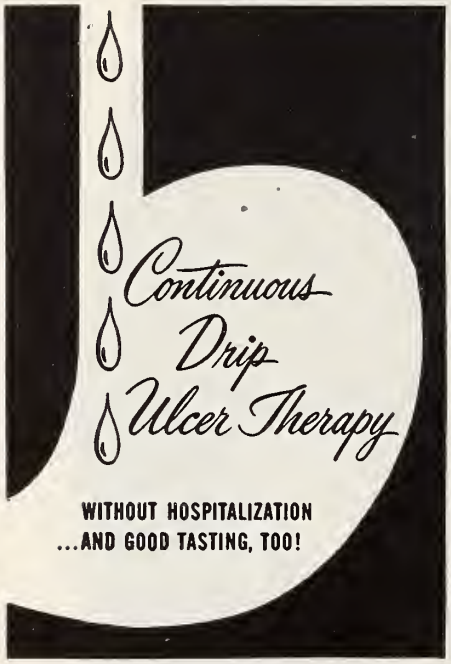
Indigency among physicians

The doctor, in many instances, lives beyond his means. It seems that this is thought to be a necessary chance to enhance his social status which will return to him subsequent financial gains which seem worth the chance. A professional man's income is exaggerated by the laity. His expenses are overlooked. His financial security in old age is not considered important enough to discuss. He is expected to contribute to all charities and keep socially and physically fit. Once his earning capacity is established, he is besieged by taxes. No matter how necessary they are, they are often financially crippling and will always be with him. As a doctor advances into his most productive years, for a period of 10 to 15 years his expenses, taxes, and family responsibilities increase. Unless he has intelligently approached the problem of systematic, regular savings, and has established this principle as a jealously guarded habit, he may well be started on a path of eventual financial insecurity. A sad road from which there seldom is self-rescue. Inability to live on an accustomed financial level invites isolation with deterioration of interests. *Beverly C. Smith, M.D. Indigency Among Doctors. New York J. Med. Oct.* 1, 1956.

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Bleeding ulcer

Two hundred admissions for gastrointestinal hemorrhage have been analyzed. Of these, 123 were due to duodenal ulcer and 22 to gastric ulcer. There were three deaths in the duodenal ulcer group but only one indirectly attributable to blood loss. The corrected mortality in this group was accordingly .8 per cent. We feel that medical therapy has resulted in a mortality rate significantly lower, by far, than the best reported with surgical intervention. Emergency surgical intervention was necessary in only two cases. Of the 22 patients with gastric ulceration, three died as a direct result of gastric hemorrhage, a mortality of 13.6 per cent. This figure is significantly higher than that due to duodenal ulcer and is in keeping with our current concept of earlier surgical intervention in patients with bleeding gastric ulcer. *S. L. Zimmerman, M.D. et al. An Analysis of 200 Admissions for Massive Upper Gastrointestinal Bleeding. Ann. Int. Med. Oct.* 1956.



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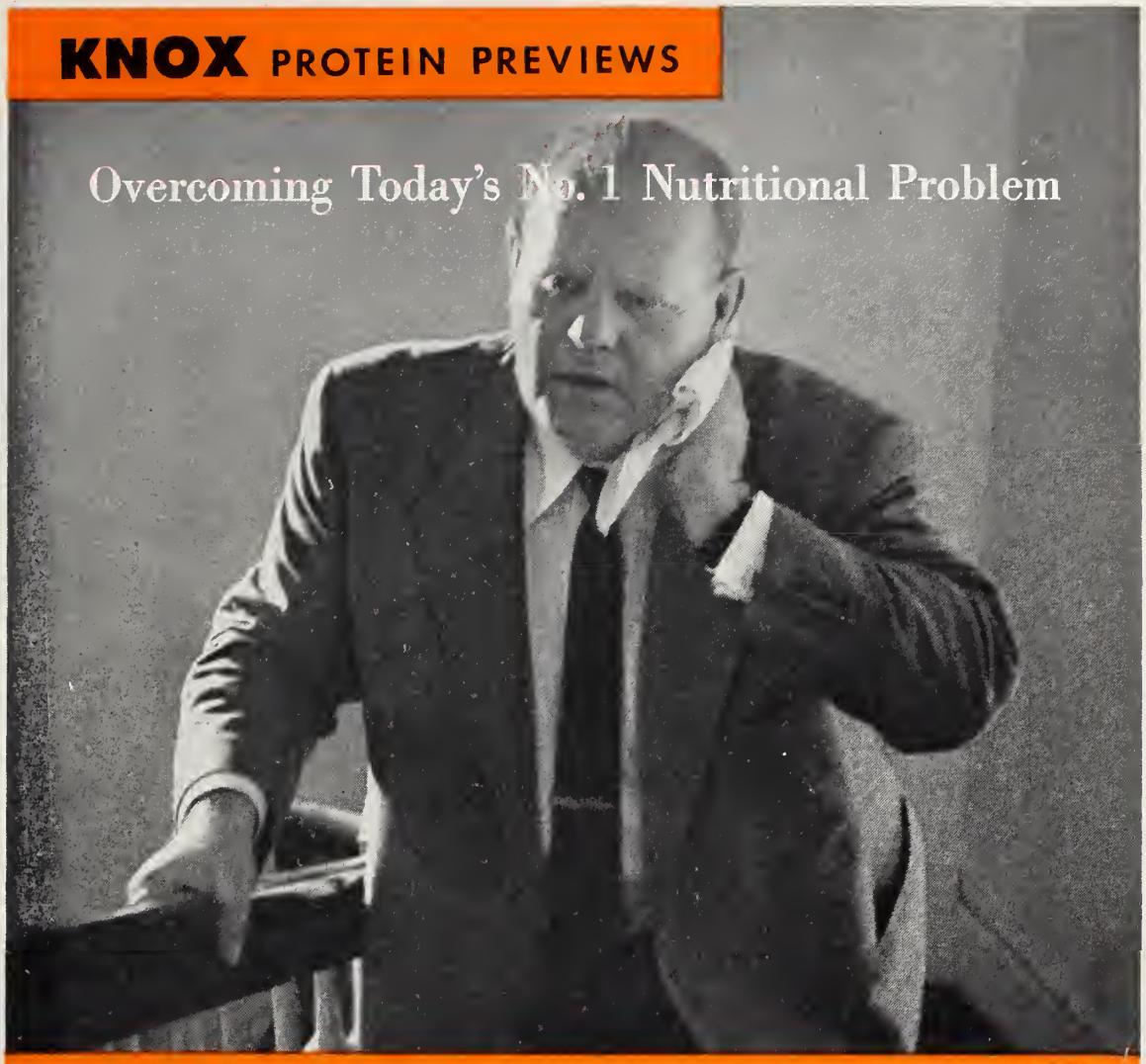
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*Steigmann, F., and Goldberg, E.: Ambulatory Continuous Drip Method in the Treatment of Peptic Ulcer, Am. J. Digest. Dis. 22:67 (Mar.) 1955.

†Mg trisilicate 3.5 gr.; Ca carbonate 2.0 gr.; Mg oxide 2.0 gr.; Mg carbonate 0.5 gr.

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A new treatment for hepatitis

There is no antiviral treatment of specific nature available against infectious hepatitis but we believe that we now have a means of management which may produce rapid recovery from this disease. In each case, clinical recovery was achieved in about a week, regardless of the original intensity of the disease. Twelve successive cases were treated with the intravenous combination of cortisone and antibiotic and it would be too much to assume that such rapid results could be coincidental since other cases of hepatitis on other services at the same time went through the usual prolonged course. Certain features of the rapid improvement manifested by our patients are of practical as well as of theoretic interest. In all cases except one, there was sudden amelioration of toxicity. In 24 to 48 hours, patients felt much better and there was marked visible improvement in the general condition. In all cases this included a cessation of nausea and vomiting, with subsequent ability to maintain adequate nutrition through normal channels. The high caloric intake or forced feeding, which is of so much importance, was at once possible. A rapid decrease in the amount of bile in the urine took place. Daily bedside specimens were inspected, and sometimes within a few hours of the start of therapy, there would be an appreciable clearing. The disappearance of bile in the urine usually preceded the point of clinical recovery and provided the signal for repeating the battery of liver chemistries. In seven to 10 days the patients were clinically well and various indices, such as icteric index, bilirubin, cephalin flocculation, and bromsulfalein retention, were often within normal limits. The blood sedimentation rate proved an exception. A factor in this rapid recovery was the powerful anti-inflammatory action of cortisone. The objection has been made that in the early stages of the disease, cortisone may interfere with the normal production of antibodies. We feel that in small doses no such undesirable action takes place. As a matter of fact, when given early enough, the anti-inflammatory action may prevent or cut short the so-called obstructive phase of jaundice seen so commonly in hepatitis. Patterson, Dingman, Schwachman, and Thorn have described the choleretic action of cortisone. This

(*Continued on page 70*)

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Pennington, V. M.: J.A.M.A. In press, 1957.

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Allschul, A. and Billow, B.. New York State J. Med. In press, 195[illegible]

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Gillette, H. E.: Internat. Rec. Med. 169: 153, 1956.

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Fazekas, J. F., Shea, J. G. and Sullivan, P. D.: GP 14: 75, 1956.

5 "Thus far, there has been very little evidence of actual habituation to meprobamate ['Miltown']. No real tolerance has been observed."
Borrus, J. C.: Med. Clinics of North America. In press, 1957.

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HEPATITIS (Continued)

may explain the decrease in serum bilirubin levels but we still believe that the primary beneficial effect lies in decreasing the edema and inflammation found in the diseased liver. The halt in the obstructive phase may follow the decrease in edema about the smaller bile canaliculi. We do not know whether the antibiotic has any direct effect here unless one were to postulate the presence of secondary infection. In any event, partial sterilization of the gastrointestinal tract by the antibiotic may be helpful in producing chemical rest for the liver. Finally, with respect to synergistic action between cortisone and the antibiotic in bringing about a rapid recovery, we can only speculate, but such synergism does seem to exist. In none of our cases was there any evidence of rebound after treatment, nor was there a relapse at any time. At first we were disturbed by our rapid ambulation in the face of blood sedimentation rates that remained elevated. We have no explanation for this phenomenon and can only note that it was seen repeatedly and could persist for three weeks after the patient left the hospital. *Max Jacobson, M.D. and Charles Ressler, M.D. Rapid Therapy of Infectious Hepatitis. New York J. Med. Oct. 1, 1956.*

‹ ›

Triiodothyronine for fatigue

In a careful study of nonmyxedematous hypometabolism, Kurland et al. conclude that the commonest complaints are lethargy, easy fatigability, nervousness, irritability, emotional instability, sensitivity to cold, headache, ill defined skeletal pain, diminished sexual potency in the male, and menstrual irregularity in the female. Four patients with this syndrome were studied in detail. The B.M.R. varied from −20 to −25 per cent but radioiodine uptake and serum protein bound iodine and serum-cholesterol levels were within normal limits. All had previously been treated with thyroid extract, but without benefit. When the patients were given thyroxine they again failed to respond symptomatically and the effect on their B.M.R. was slight. But triiodothyronine, either alone or in

(*Continued on page 74*)

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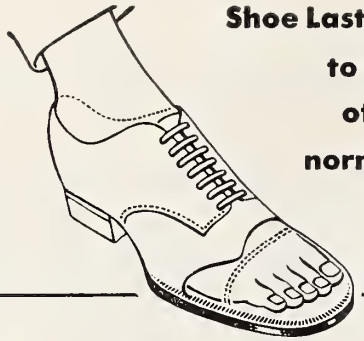
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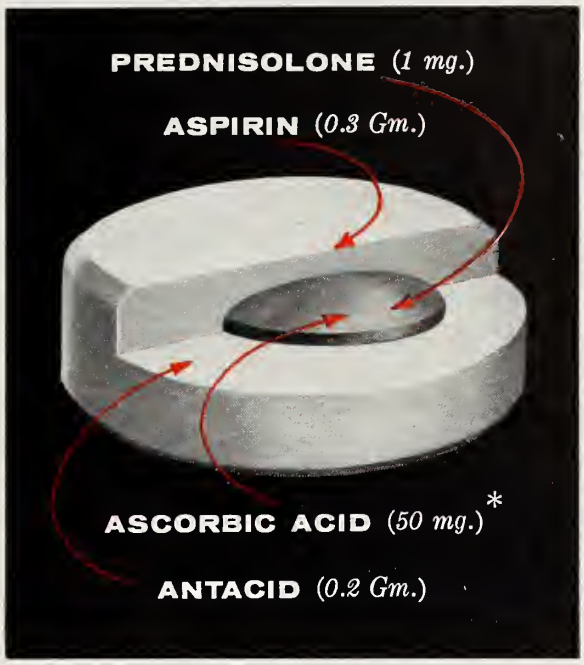
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TRIIODOTHYRONINE (Continued)

association with thyroxine, raised the B.M.R. and abolished the symptoms. (Furthermore, Tittle has reported six cases with B.M.R.s ranging from −28 to −36 per cent, which appeared to respond to triiodothyronine but not to thyroid extract.) For these observations, Kurland et al. put forward several alternative explanations. One is that triiodothyronine may be better absorbed than either thyroid extract or thyroxine. Another is that people with this syndrome have a peripheral insensitivity to thyroxine, either because they cannot convert it to a more active form, because it cannot penetrate into their cells, or because triiodothyronine is necessary for the metabolism of thyroxine and they cannot make triiodothyronine. Meanwhile, it still has to be demonstrated that people with nonmyxedematous hypometabolism are unequivocally benefited by triiodothyronine; and this would require a rigorously controlled statistical study with the substitution of a placebo for the drug without the knowledge of either observer or patient.

The problem is far from being academic. Most patients attending doctors' surgeries, including nearly all who feel they need a tonic, have one or more of the symptoms attributed to nonmyxedematous hypometabolism and since it clearly would not be feasible to measure the B.M.R. in all these cases, doctors may wonder whether they should not give triiodothyronine an empirical trial in all patients complaining of lethargy, easy fatigability, and the rest. Such a trial is now being encouraged by at least two important pharmaceutical houses, and we have ourselves published advertisements in which they suggested that triiodothyronine should be used for hypometabolic states and metabolic insufficiency. But though we think that responsible manufacturers have a right to make reasonable claims through our advertisement columns, we preserve our equal right to disagree editorially with what they advise; and this is, we believe, an occasion for sharp disagreement. Our opinion is that triiodothyronine should not be used for the purpose now so widely proposed. To put this drug on the market was proper and praiseworthy, for it probably is the best available for myxedema coma. But its administra-

(*Continued on page 76*)



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TRIIODOTHYRONINE (Continued)

tion to relieve such symptoms as physical and mental sluggishness, irritability, depression, and nervousness is unjustified in the present state of knowledge. In a statement more detailed than anything we have published, one of the firms has grouped these and similarly nonspecific symptoms under the title, metabolic insufficiency. This, it is said, "may affect isolated tissues or organs of the body and therefore, may not significantly alter the B.M.R." There may be no objective signs or tests by which this syndrome can be recognized but "the diagnosis of metabolic insufficiency can be readily verified or discounted by a short therapeutic trial." What, in effect, this means is that patients complaining of almost any symptom which has no previous cause should be given triiodothyronine to see whether they feel any better. Were this advice widely followed, the least that could happen would be a good deal of diagnostic confusion; and serious harm might be done if, for example, people with severe coronary artery disease were inadvertently treated with large doses. This powerful agent is certainly not one that should be prescribed indiscriminately as a tonic. *Editorial. Triiodothyronine for "Metabolic Insufficiency." Lancet, Oct.* 20, 1956.

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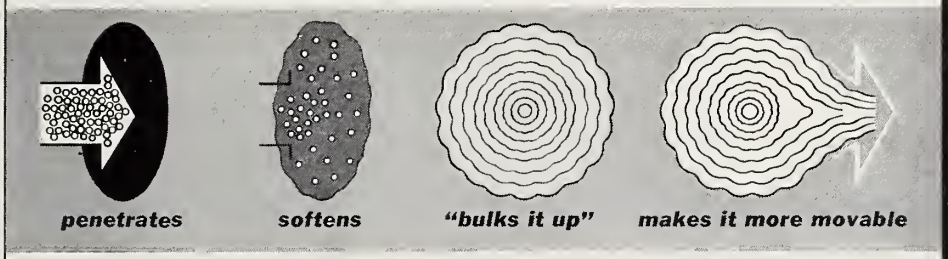
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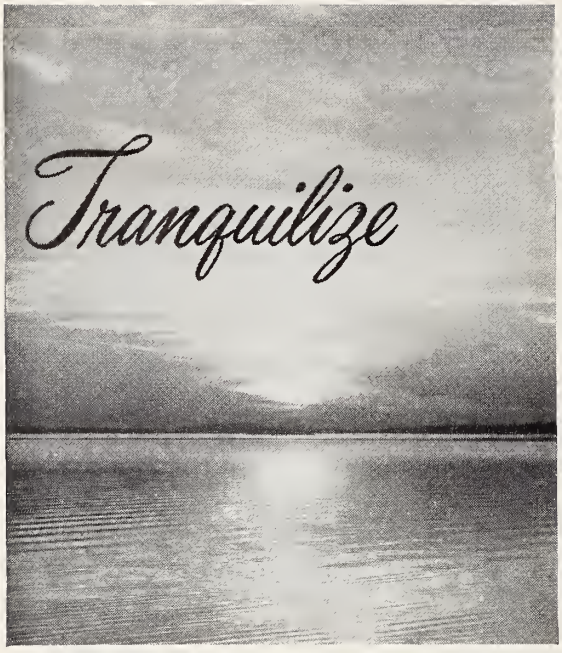
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3. Eighty-five per cent of all our patients with nasal polyps showed an excess of eosinophils in their nasal secretions.

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5. Intracutaneous skin testing was done in all cases. Significant positive skin reactions were obtained in 60 per cent of cases, indicating that reagins are not a necessary prerequisite to the formation of polyps. This is about the same percentage of positive skin tests as is normally found in atopic respiratory conditions.

6. Frank infection of the nasal accessory sinuses was absent in three-fourths of all cases. This would suggest that polyps can develop in the absence of infection.

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(*Continued on page* 84)

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1. Weil, L. L.: J. Florida Acad. Gen. Pract. 4:9 (July) 1954. 2. Williams, Henry L.: J. Michigan State Med. Society 51:572-576 (May) 1952

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POLYPS (Continued)
treated with ACTH and cortisone. There was in addition to alleviation of asthma, regression or total disappearance of the nasal polyps. In another group of patients with nasal polyps, standard allergic management was employed, including the removal of offending foods and inhalants. There resulted a diminution in the size or total disappearance of the nasal polyps. *Robert A. Chait, M.D. Allergic Rhinitis and Nasal Polyps. New York J. Med. Aug.* 1, 1956.

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Why he drinks

The author believes the chronic compulsive drinker's search for pleasure is the basic root of his trouble. It accounts for his difficulty in honestly wanting to give up his drinking. The addict is often relatively infantile in his emotional reactions. His addiction satisfies some inner instinctual drive and he tries to cling to this pleasure achieved by repeated drinking, but he either drinks too much and falls into a stupor or drinks too little and finds himself in painful awareness of reality. He makes endless attempts to reach a state of continuous pleasure that always slips away from him. He keeps up his compulsive type of drinking until he gets into serious social, psychologic, or physical complications and has to seek medical and psychiatric attention. Only when he comes to realize that the painful phases of his indulgence far outweigh the length of the pleasurable ones does he honestly desire to quit drinking, with a more normal reaction to his emotional responses. If he really wants to substitute something else more satisfying to him than his repeated alcoholic pleasures he is a favorable candidate for either medical, psychiatric, or AA therapy. Prolonged supervision along these lines will enable the co-operative patient to gain insight and enable him gradually to utilize his new aids to a more satisfactory way of living without alcohol. Physicians must change their attitudes toward the disease to one of understanding and a desire to help, if the treatment is to be effective. *A. E. Bennett, M.D. Alcohol Addiction. California Med. Oct.* 1956.

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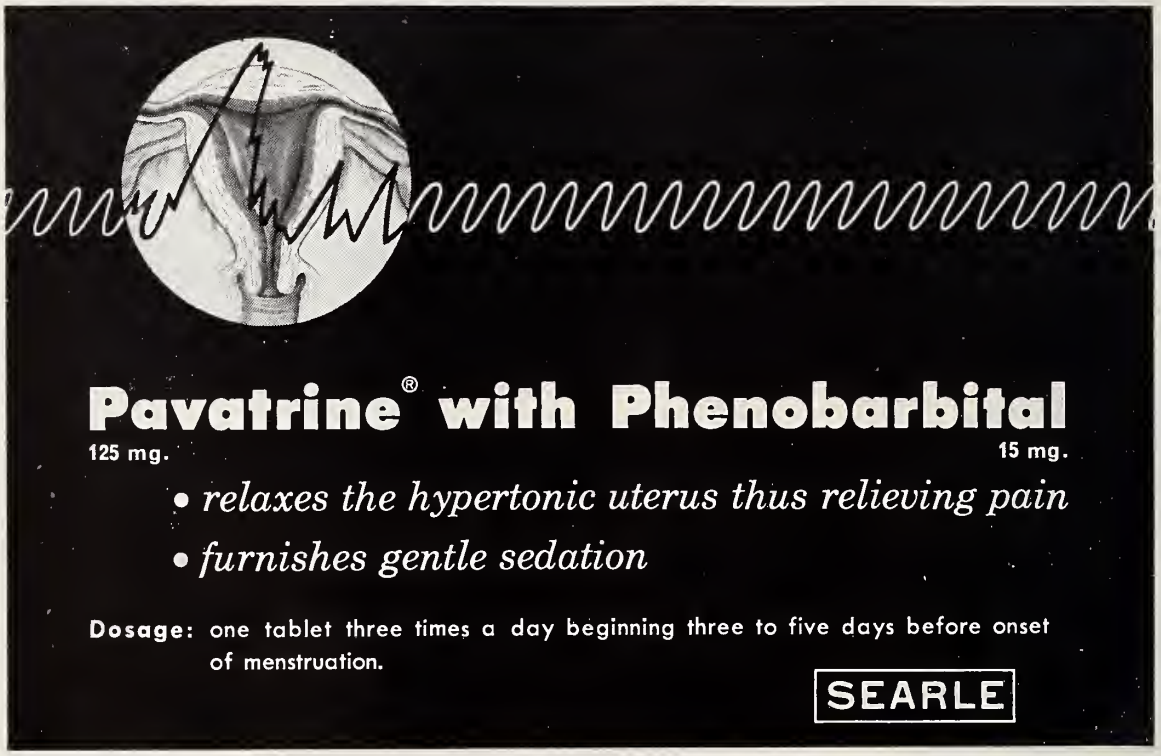
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Reduction diets; measured or weighed?

A comparative study was made at the Mayo Clinic of questionnaire data regarding loss of weight reeeived from 49 patients who had been taught to use a weighed reduction diet and from 56 patients who had been taught to use an approximate-measure reduetion diet. Patients using the weighed diet lost a greater number of pounds than did those using the approximate-measure diet. However, fewer of the patients using weighted diets attained weights within 10 per eent of their ideal weight than did those using the approximate-measure diet. Whether a weighted reduction diet or an approximate-measure reduetion diet is prescribed depends on the immediate objeetive with regard to the person coneerned. If the objective is the loss of as great an amount of exeess weight as possible without necessarily attaining ideal weight, the weighted reduction diet would be indieated. Otherwise it is optional as to which of these two types of diet is prescribed. In view of the fact that more time must be spent with the patient to teaeh him the weighted reduetion diet, it would appear more praetieal to use the approximate-measure reduetion diet. No matter what type of reduction diet may be used, follow-up of the patients at intervals of six months is advised. Perhaps this would encourage them to continue reduetion of weight until the ultimate goal of ideal weight has been reaehed. Too few patients reported failure to take vitamin supplements to justify any eonelusions about the possible effect sueh failure might have on the sueeess or lack of sueeess in reduction of weight. The few patients who did not take vitamin supplements were neither more or less suecessful than were those who did take them. Similarly, no eonclusions may be drawn as to the effect of medications designed to control appetite or increase metabolism. *Ruth E. Franklin, B.S. and Edward H. Rynearson, M.D. Comparative Effectiveness of a Weighted Reduction Diet and an Approximate-Measure Diet. Minnesota Med. Oct.* 1956.

in dysmenorrhea



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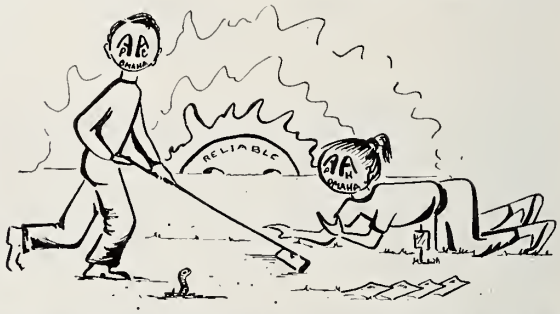
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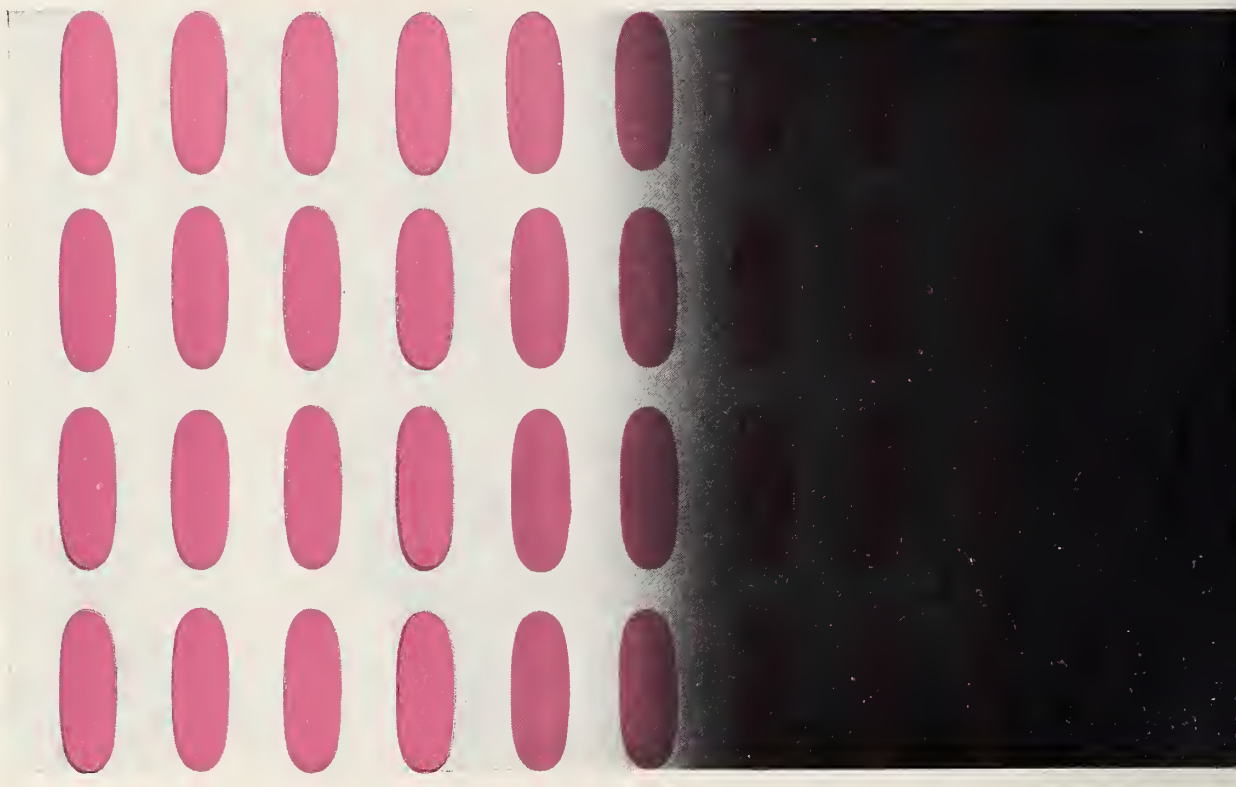
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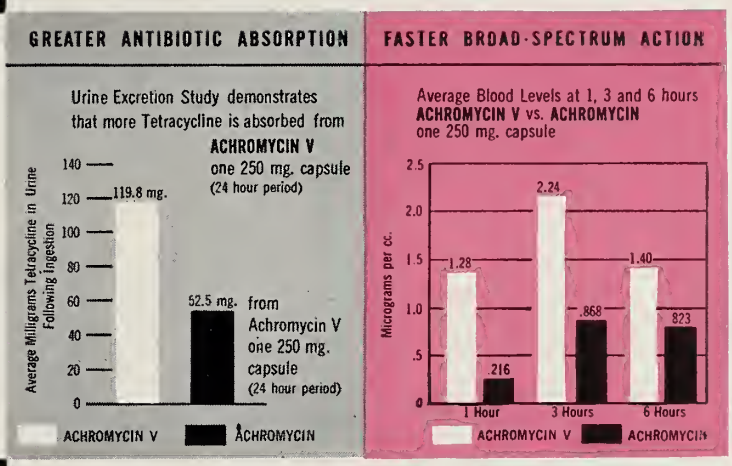
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The Month in Washington



Washington, D. C. — By approximately the mid-term point in its first session, the 85th Congress had shown enough interest in health legislation to hold a variety of hearings, but there was no evidence that many major bills would be passed before adjournment.

Actually, it was not until three months after the session opened that the Administration sent up to Congress two bills it regards as important — one would change the doctor draft act and the other would authorize small commercial companies to pool part of their resources to stimulate expansion and experimentation in health insurance.

Even then, the Department of Health, Education, and Welfare had not released its draft of legislation for federal grants to medical, dental and osteopathic schools for construction and equipment. On this, there was some reluctance to act until Capitol Hill had decided on the administration's bill for U.S. aid to general education.

Of all these bills, indications were that progress was assured on only one, that providing some revised arrangement for the selective draft of physicians, dentists and "allied specialists." The special doctor draft act, in effect for almost seven years, is scheduled to expire on July 1. Because Defense Department insists it still needs special authority to draft physicians and other professional health personnel by professional classification, the alternative was continuation of a modified doctor draft act or changing the regular draft act.

Meanwhile, a number of other bills had been studied at hearings. They include:

Changes in medical aspect of civil aviation regulations. Witnesses are widely divided on this measure that would set up an Office of Civil Aviation Medicine within the Civil Aeronautics Administration and give the Air Surgeon General who would head the office considerably more authority than now is exercised by U.S. medical officials in this field. There was no official sponsorship of this from the federal governmental level. It was opposed by the Department of Commerce (where CAA is located) and the Civil Aeronautics Board. However, support came from the outside, including testimony from Dr. Jan Tillisch of the Mayo Clinic, Dr. William Ashe, chairman of the department of preventive medicine, Ohio State University, and Dr. Herbert F. Fenwick, president of the Civil Aviation Medical Examiners. Dr. Tillisch headed an AMA ad hoc committee that had started a study of the problem, but he testified as an individual.

Veterans medical care. The House Veterans Affairs Committee had held extensive hearings on a bill to further restrict admission of non-service connected cases to Veterans Administration hospitals, but there were no developments beyond that to encourage sponsors of this legislation.

Civil defense reorganization. Here again a wide split developed at the hearings on just how to reorganize the federal government's participation in civil defense. The Administration wanted to strengthen the U.S. civil defense arm (the Federal Civil Defense Administration), but

(*Continued on page* 34)



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WASHINGTON (Continued)

without going to the extent of making a cabinet-rank Department of Civil Defense, which is the goal of Chairman Chet Holifield (D., Calif.) of the subcommittee that had studied civil defense for more than a year.

Control of barbiturate and amphetamine drugs. The objective of bills before the House Interstate health subcommittee is to extend federal control to take in the manufacture, compounding, processing, distribution and possession of habit-forming barbiturates and amphetamines. This would be achieved by demonstrating that intrastate control of the drugs is essential to achieve interstate control, a philosophy advanced for years by some federal officials.

While manufacturers, compounders, processors and handlers would have to list their names and places of business with HEW and to maintain complete records, physicians would not have to comply with these regulations.

ECONOMY ADVOCATES LOSE

Pressures for economy that had been evident early in the session seemed to lose their effectiveness when Congress really set to work on the budget for the Department of Health, Education, and Welfare. Whereas in first (non-record) votes the House cut scores of items, it simply reversed itself when roll-call votes were demanded in the final go-around.

As an example, no reductions at all were made in funds for the research institutes, $50 million was restored for grants to help build water pollution treatment plans, $1.3 million was restored to the Food and Drug Administration. A $5 million cut in money for general public health grants to states was sustained by the House — but this money will have to be provided later if the House estimate of the extent of the obligation proves too low.

Economy advocates tried without success in the House to cut $21 million from the Hill-Burton hospital construction program.

While in theory the Senate is privileged to make its own cuts in a money bill coming to it from the House, in practice the Senators generally restore much of the money cut by the House and occasionally (as last year) vote large boosts over House figures. So the possibility now is for even higher health and medical budgets before the appropriations bills finally are enacted.

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MAY, 1957
VOL. 111, NO. 5

Pelvic Tumors Complicating Pregnancy

HENRY P. LATTUADA, M.D., DANVILLE

PELVIC tumors occur frequently during the childbearing period, and when they develop during pregnancy may cause serious complications. These tumors may be genital (uterine or ovarian) or extragenital (congenital ectopic kidneys, neurogenic, osseous, inflammatory, or metastatic).

Most pelvic tumors complicating pregnancy arise from uterine myomas or ovarian cysts. When they are less than 6 cm. in diameter, the course of the pregnancy may be uneventful and delivery normal. If they are larger, several complications may occur:

1. Torsion of ovarian cysts or pedunculated myomas is three times more common during pregnancy than in the nonpregnant state, and is particularly prone to occur during the puerperium because of the free mobility of the subinvoluting uterus. Intracystic hemorrhage usually is associated with torsion, but may occur alone.

2. Rupture of a dermoid cyst may cause peritonitis; or suppuration may take place with or without torsion, and manifests itself during the puerperium resulting from lymphatic spread of infection from the uterus.

3. Spontaneous abortion occurs about twice as often with a myomatous uterus as compared with the normal uterus.

4. Vaginal bleeding or hemorrhage may be due to a submucous pedunculated cervical myoma (these do not have to be large to cause bleeding). Premature separation of the placenta may occur by an enlarging edematous or degenerating myoma partially separating the placenta from the uterine wall.

5. Malposition of the fetus from myoma distorting the uterine cavity may interfere with labor.

6. Obstructive dystocia may occur during labor if a large ovarian cyst, myoma, or extraperitoneal sacral tumor prevents entrance or descent of the presenting part through the birth canal.

INCIDENCE

Grandin[1] in 1949 reported an incidence of 2.1 per cent pregnancies complicated by myomas. Parks and Barter[2] in 1952 reported an incidence varying from 0.3 to 7.2 per cent. During pregnancy, many small myomas may be discovered, but usually only those of 6 cm. or more in diameter become clinically significant. Serious complications of the pregnant myomatous uterus occur more commonly in negro than in white patients, and more often in elderly primigravidas than in any other age or state of parity.

Presented before Section on Obstetrics and Gynecology, 116th Annual Meeting, Illinois State Medical Society, Chicago, May 15-18, 1956.

The literature on ovarian tumors complicating pregnancy has been reviewed by Hamilton and Higgins[3], Haas[4], Dougherty and Lund[5], and Gustafson, Gardiner, and Stout[6]. Reports vary from 1:1000 to 1:4000. The true incidence is probably higher as tumors which remain asymptomatic may escape diagnosis until the late puerperium.

The subject of extragenital pelvic tumors was studied by Lovelady and Dockerty[7] in 1949. They were present in the birth canal in a series of 127 patients and 10 of these tumors were associated with pregnancy. Twelve tumors (9 per cent) comprised the neurogenic group. Lesions arising in bone were present in 18 patients. The miscellaneous group of tumors contained 14 examples and included myogenic tumors, inflammatory masses (often secondary to anal fistulae), fibromas, and metastatic carcinoma. Seventeen malignant neoplasms found in the entire group (24 per cent) were metastatic.

DIAGNOSIS

Careful pelvic examination during the first trimester of pregnancy usually will identify the existence of a uterine myoma, ovarian cyst, or extragenital tumor. However, the interpretation of the pelvic findings may present diagnostic and therapeutic difficulties. In early pregnancy, myoma or ovarian cyst may be confused with ectopic gestation, hydatidiform mole, or anomalous uterus. A soft and symmetrical myoma may be mistaken for a pregnant uterus. When in doubt, a biologic pregnancy test is indicated. A flat film of the abdomen followed by an intravenous pyelogram may help in diagnosing a dermoid cyst or an ectopic pelvic kidney.

TREATMENT

First Trimester: While myomas usually increase in size during pregnancy, it is doubtful whether there is any true proliferation of tumor tissue. Enlargement of the myoma is due largely to edema. Histologically these tumors show only edema and hyaline degeneration. Degenerative processes resulting from alteration in venous return occur in tumors embedded in the uterine wall, whereas acute circulatory strangulation is found only in twisted pedunculated tumors.[2] Myomas increase the incidence of spontaneous abortion.

Treatment of abortion complicated by myomas may require more operative manipulation than with a normal uterus. One of the major complications of myomas during early pregnancy is abortion, followed by degeneration and infection. Fever, tenderness, and excessive bleeding may suggest degeneration with superimposed infection. In the circumstances, hysterectomy may be the operation of greatest benefit to the patient[2].

Ovarian cysts of less than 6 cm. frequently are found during early pregnancy. Unless these cysts are causing symptoms, it is better to wait until the middle of the second trimester before making a final decision regarding their removal. Functional cysts regress spontaneously and corpus luteum function is taken over by the placenta, thus minimizing the risk of removing a corpus luteum (verum) of pregnancy. By the 16th week of gestation, oophorectomy rarely entails any danger of abortion. However, if torsion or intracystic hemorrhage occurs, immediate surgery is indicated.

Second Trimester: During the middle months of pregnancy, changes in size, position, and blood supply of myomas may cause significant symptoms. Subserous tumors on the anterior wall give rise to pressure symptoms and disturbance of the bladder. Persistent or increasing pain in a myoma, is the symptom most likely to create an indication for surgical intervention. Myomas 6 cm. or more in diameter create the highest incidence of complications, particularly during the second trimester when acute appendicitis and ovarian cysts may be overlooked in the presence of painful myomas. At times, it is impossible to differentiate between the pain from threatened abortion and that of a degenerating myoma. Occasionally abortion and degenerating myomas co-exist. When a definite diagnosis of such a combination of circumstances can be made, hysterectomy is indicated as the safest course of treatment[2].

During the middle months of pregnancy, surgery is indicated as soon as diagnosis is made of an ovarian cyst 6 cm. or larger. At this time, any possible endocrine deficiencies do not confuse the issue, and single or bilateral cysts can be removed usually without danger of abortion.

Third Trimester and Delivery: During the last part of pregnancy some of the following serious complications may be encountered as a result of uterine myomas[2]: (1) Fetal malpositions resulting from tumors that distort the

uterine cavity; (2) Inertia dystocia occurring in the patient whose myometrium is disorganized by multiple myomas; (3) An otherwise asymptomatic myoma causing obstructive dystocia due to its size and location in the pelvis.

A patient who has had myomectomy prior to or during pregnancy has to be observed carefully in late pregnancy. Defective uterine scars from myomectomy, particularly those infiltered with adenomyosis, may rupture during the course of labor. Where there has been a deep excision of a myoma, the patient should be treated as if she had had a previous cesarean section. If there is evidence of tumor degeneration, obstructive dystocia, or fetal malposition in late pregnancy, elective cesarean hysterectomy may become the treatment of choice, particularly with large myomas that occupy part of the true pelvis. Following delivery, hemorrhage may occur from submucous myomas that have been disturbed by delivery of the infant or placenta or from atonicity of the uterus. Torsion of a pedunculated myoma frequently occurs during involution of the uterus.

The discovery of a large ovarian cyst late in pregnancy calls for temporizing. Operation carries the risk of premature labor and strain on the abdominal wound. Oophorectomy is not done unless an emergency arises. During labor, in the absence of obstruction, delivery from below may be awaited. If obstructive dystocia occurs, forceful displacement of the cyst is dangerous because of the possibility of rupture with the dissemination of irritating material (dermoid cysts) into the peritoneal cavity. When the tumor is immobile, the only treatment is an elective cesarean section with removal of the tumor at the same time. During the puerperium, torsion of the cyst demands immediate surgery[8].

Therapeutic abortion is not indicated when an extragenital or extraperitoneal tumor is discovered during pregnancy. The majority of these tumors are benign and the ones that are malignant recur slowly. If the pregnant uterus has not become incarcerated in the pelvis and the tumor is large enough to obstruct labor, the pregnancy should be allowed to proceed to term, and delivery should be effected by cesarean section. Subsequent removal of the tumor can then be carried out[7].

SUMMARY

Ovarian Tumors: Functional cysts of the ovary less than 6 cm. are found frequently during early pregnancy. They usually are corpus lutea cysts, and regress as pregnancy advances. If torsion or hemorrhage occurs, differential diagnosis from ectopic pregnancy cannot be made and surgery is indicated. When the ovarian tumors are larger than 6 cm. they may be true neoplasms and should be removed after the 16th week of pregnancy unless torsion occurs. Tumors suspected of being solid should be removed promptly. Management of ovarian tumors found during the second trimester of pregnancy is not much different. Surgery is indicated as soon as diagnosis is made. The discovery of a medium sized or large cyst during the last trimester of pregnancy calls for temporizing. Operation carries the risk of strain on the abdominal wound if premature labor should begin following surgery. At term, management will depend upon the size and location of the tumor and the age of the patient.

Uterine Myomas: The majority of patients during pregnancy with small uterine myomas will not encounter any major difficulties. However, the presence of a sizable tumor during pregnancy may create a real obstetrical complication. The problem is further emphasized by the fact that the combination of pregnancy and myomas tends to occur in the primigravida in the later years of her childbearing age, and that this particular pregnancy may represent her last reproductive opportunity. Early pregnancy complicates pre-existing myomas, causing them to enlarge resulting in a relatively high incidence of abortions. Abortion followed by tumor degeneration and infection often is best treated by hysterectomy. Large myomas distorting the uterine cavity may cause fetal malposition; or if the tumor is located low in the pelvis, it may cause obstructive dystocia by blocking the birth canal. Cesarean section with removal of the tumor, if possible, is the only treatment.

Extragenital Pelvic Tumors: When an extragenital pelvic tumor is found in a pregnant woman, every available means of diagnosis (noninjurious to the pregnancy) should be employed to determine the nature of the tumor. Since the majority of these tumors are benign and the ones that are malignant recur slowly, therapeutic abortion is not indicated. The pregnancy should be allowed to proceed to term, and

if large enough to obstruct labor, delivery should be by cesarean section.

Nine case reports of various tumors complicating pregnancy are reported.

CASE I: Mrs. R. S., age 33 years, primigravida, white, was first seen on November 10, 1954, when she was approximately four months pregnant. She had had one previous admission to the hospital and was observed for threatened abortion. She was having slight vaginal bleeding, but no uterine contractions. Vaginal examination revealed a necrotic bleeding, soft myoma on a long pedicle protruding from the cervical canal. A chromic suture was tied around the pedicle and the myoma was removed. She had no further bleeding and was delivered spontaneously on April 12, 1955 of a 6 pound, 4 ounce, living baby girl. Postpartum examination, six weeks after delivery, showed no evidence of myomas.

CASE II: Mrs. T. T., age 33 years, primigravida, colored, had her last menstrual period December 10-15th, 1955. Pregnancy was uneventful until April 9, 1956 when she began having pain in her right lower abdomen. Patient was admitted to the hospital on April 13, 1956, because the pain became more severe. Pelvic examination revealed an enlarged uterus consistent with 16 weeks' gestation with a 10-12 cm. tender mass on the right side of the uterus. Diagnosis of pregnancy with twisted ovarian cyst was made and laparotomy was done. At the operation a necrotic degenerative pedunculated myoma was found and excised. She did not abort and left the hospital on the ninth postoperative day.

CASE III: Mrs. I. H., age 35 years, primigravida, white, was referred to me by her attending physician because of amenorrhea of two months duration and uterine enlargement consistent with a five month gestation. She was first seen on March 30, 1951. Her last menstrual period was January 28-February 4, 1951. At the first examination, she was having slight pain and tenderness over the right side of the abdomen. The fundus of the uterus was at the level of the umbilicus, and felt slightly irregular. Bi-manual pelvic examination revealed the cervix displaced beneath the symphysis, and the cul-de-sac contained a firm immovable mass. No fetal heart sounds could be heard. A flat plate of the abdomen showed the outline of the enlarged uterine mass, but no fetal skeletal could be seen. A Friedman pregnancy test was done and was reported positive. Patient was again seen on May 15, 1951. The height of the uterus (symphysis to fundus) measured 27 cm. On June 12, 1951, the height of the uterus measured 31 cm. The patient was now having a brownish red vaginal discharge. Because of the rapidly increasing size of the uterus with a positive pregnancy test, a diagnosis of possible hydatidiform mole was made. On July 12, 1951, another flat plate of the abdomen was made. This film revealed a fetal skeleton of 20 weeks' gestation occupying the upper left abdominal quadrant. The possibility of pregnancy associated with a pelvic tumor or an extrauterine pregnancy was considered, and it was hoped to carry the patient along for another two months when a viable baby could be obtained by cesarean section. On the morning of July 19, 1951, the patient's husband called in, stating that the patient had begun bleeding vaginally and was having severe pain in the abdomen. She was admitted to Lake View Hospital, where a supracervical hysterectomy was done. The uterus measured 30x25x15 cm., and weighed 6,100 grams. The myoma measured 20x15 cm., and the uterine cavity contained a stillborn male fetus of approximately 5½ months gestation. Patient was given one blood transfusion, and made an uneventful postoperative recovery.

CASE IV: Mrs. N. L., gravida 3, para 1, was delivered of her second pregnancy in September, 1953. At postpartum examination, in November, she was told she had a left ovarian tumor about the size of a large orange. She was advised at that time to have surgery but decided she would wait until after Christmas. However, during the holiday week, she again became pregnant. On the morning of February 22, 1954, she began having severe pain in her left lower abdomen. A laparotomy was done and a twisted dermoid cyst was removed. The uterus was enlarged to the size of a nine week gestation. Patient was given progesterone for 10 days postoperatively and did not abort. She was delivered of a normal female infant on September 14, 1954.

CASE V: Mrs. J. T., age 34, gravida 5, para 4, white, was seen on April 8, 1956, complaining of pain in the lower abdomen and right flank. Her last menstrual period was February 20-26th, 1956. Pelvic examination revealed a large, tender cystic mass in the right lower abdomen and flank.. The corpus uteri was palpated to the left and behind the cystic mass. At laparotomy, a 20 cm. right, twisted, gangrenous ovarian cyst was found and removed. The uterus was enlarged to the size of a 10 week gestation. Patient did not abort and left the hospital on the 10th postoperative day.

CASE VI: Mrs. D. G., age 25, primigravida, white, was first seen on December 11, 1955, when she was admitted to the hospital by her attending physician because of severe pain in left abdomen and flank and vaginal bleeding. She had been delivered two weeks previously of a 7 pound, 1 ounce, living female infant. At the time of examination, patient was bleeding rather heavily and fullness was palpated in the left flank. There was considerable tenderness over the entire abdomen, and the uterus could not be definitely outlined. A blood count revealed hemoglobin of 9.8 gms., (67%); the WBC was 14,000. Her temperature was 101°F. A diagnosis of retained placental tissue with subinvolution of the uterus or a broad ligament hematoma was made. Patient was given a blood transfusion and taken to surgery. Under general anesthesia, the uterine cavity was explored and a few fragments of placental tissue were removed. Palpation of the abdomen under anesthesia revealed the presence of a left

pelvic tumor. Laparotomy was done and a hemorrhagic twisted left ovarian cyst was found and removed.

CASE VII: Mrs. N. R., age 18 years, primigravida, white, was delivered by low forceps and episiotomy of a normal female baby on September 3, 1952. During postpartum examination, a large orange sized left cystic tumor was found. A laparotomy was done and a parovarian cyst was removed.

CASE VIII: Mrs. M. D., age 24 years, gravida 2, para 2, white, had a history of prolonged labors (30 hours with first, 20 hours with second), hypertension, and one attack of pyelitis during her second pregnancy. During postpartum examination, following birth of second baby, her attending physician found a right pelvic tumor behind the uterus. Diagnosis was made of ovarian cyst or fibroid tumor of the uterus. Laparotomy was done at St. Elizabeth Hospital on September 17, 1952. Examination of the pelvis revealed normal uterus and adnexae. Behind the uterus was a retroperitoneal mass at the level of the sacral promontory. The mass was slightly movable. Diagnosis of fused, pelvic kidneys was made. Appendectomy was done and abdomen was closed. An intravenous pyelogram done later revealed the fused pelvic kidneys.

CASE IX: Mrs. J. C., age 34 years, gravida 2, para 1, white, was admitted in labor to St. Elizabeth Hospital at 1:30 p.m., September 21, 1949. She continued to have regular active uterine contractions that afternoon and all night. Her attending physician did a vaginal examination at 9:00 a.m., the following day, and found what he thought were two fetal heads. He made a diagnosis of twin pregnancy. He ruptured the membrane of the accessible presenting part, although the head was still floating. Consultation was requested, three hours later, because the presenting part would not engage. Sterile vaginal examination revealed two rounded presenting parts, although the posterior one was lower, felt rubbery, and could not be moved. Pelvimetry X-rays revealed one fetus with the fetal head displaced forward, away from the pelvic inlet by a large retroperitoneal tumor mass. Patient was delivered by cesarean section of a 7½ pound, living male infant. Upon elevating the uterus, at the bifurcation of the aorta, a large soft tumor mass was found extending into the posterior portion of the pelvis. Biopsy of the tumor mass was not done. I did not see the patient again after she left the hospital. Her attending physician informed me she died 18 months later. Autopsy was not obtained. The tumor was believed to be a sarcoma.

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Prophylactic use of antibiotics

A knowledge of the effectiveness of the various antibiotic agents is imperative in order to obtain the best results in preventing and treating infections. There is no panacea, no single agent, that can be used routinely or tolerated by every patient. In civilian surgical practice, the prophylactic use of antibiotics has spread to the point where it is now completely out of hand. However, it can be of value, in my opinion, under the following conditions:

1. Elective surgical procedures performed in contaminated or infected areas such as the gastrointestinal, respiratory, or genitourinary tract.

2. Contaminated wounds of violence.

3. Cases in which an indwelling catheter becomes necessary as a supportive method of therapy.

4. Surgical procedures in patients who have derangement of the urinary tract.

5. Emergency operations in the presence of associated and unrelated infection such as acute upper respiratory infection.

6. Injuries or operations of the oral and pharyngeal cavities in patients with pre-existing heart disease.

7. Probably, operations on elderly patients with pre-existing pulmonary disease. *William A. Altemeier, M.D. A Current Evaluation of the Antibiotics in Surgery. Postgrad. Med. Oct.* 1956.

Basic Treatment of Fractures of the Mandible

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TO one familiar with the treatment of bony fractures elsewhere in the body the subject of mandibular fractures may seem to be simplicity itself. Surely it embraces no more than reconstitution of the anatomic form to allow normal function. A more than superficial appraisal of the subject suggests that it has either been deliberately avoided or accidentally passed over in current literature on fractures. Two current textbooks of fracture therapy published in this country are barren on the subject, and the recent excellent outline of fracture treatment published by the American College of Surgeons does not mention facial bone fractures. Certainly there are marked similarities in principles of treatment for fractures of the mandible and for fractures elsewhere because the same endogenous processes of repair are present when the fragments are properly apposed.

There are, however, certain significant differences between fractures of this member, and for instance, fractures of an extremity. These differences are inherent in the specific peculiarities of the mandible itself. Without cognizance and allowance for such individuality, success of treatment is likely to be disappointing.

The specific peculiarities of the mandible which dictate successful treatment of fractures may be enumerated:

1. The mandible is a "U" shaped bone bent to lie in two planes.
2. It has strong motivating muscles acting at multiple insertions by leverage.
3. Its body is occupied largely by a tooth bearing alveolar process on the superior aspect.
4. It articulates with the skull proper by two eminences supported by thin surgical necks, and these eminences contain the growth of the member.
5. The mandible contains much more dense cortical bone than other bones of the face and skull, and thus is the only facial bone that can be fractured by indirect as well as by direct violence.
6. The mandible gives anterior support and attachment to the tongue, and by its continuity affords a definite safeguard against airway embarrassment.
7. The mandibular condyles lie in close proximity to the base of the skull and cranial contents, and this is of prime importance when considering it as a site of violence.

Let us consider how these characteristics of the mandible must dictate our treatment of its derangement. Its unusual form, coupled with somewhat separated attachments of powerful muscles, will be a large factor in fragment apposition. That these muscles are powerful is attested by recorded biting pressures of adult humans in excess of 250 lbs. per square inch. Consider that in comparison to 20 lbs. per square inch which is excellent for a well developed adult to exert with a pencil held in a "pen grasp." Following the original fragment displacing force of the trauma which produces a fracture, the muscles of mastication are free to further displace fragments or resist their realignment. The external pterygoid, when unapposed, will move its fragment medially and forward; the temporalis pulls strongly up and back; the masseter acts to displace its fragment upward, slightly forward and laterally, and the internal pterygoids upward and forward motion compliments the masseter, but because it is much weaker its medial pull is usually overbalanced by that member. The suprahyoid group of muscles active on the mandible (mylohyoid, geniohyoid, digastric) displace anterior fragments downward and posteriorly, and in addition the mylohyoid draws lateral fragments medially, and the digastrics tend to distract fragments of a symphysis fracture.

That the mandible has a tooth bearing func-

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tion must be considered in its treatment because any fracture of the body which passes through an alveolus is thus compounded. It is practical to consider any fracture of the mandibular body (even if edentulous) a compound fracture due to the thin though densely adherent gum tissue on its superior surface.

The two condylar heads contain growth centers for the downward and forward growth of the mandible. Failure of successful treatment of fractures here in a child inevitably will result in a chinless, "birdface" deformity with or without ankylosis of the joint. The sequelae in adulthood vary from a chronic traumatic arthritis with only annoying symptoms to bony ankylosis at the site of joint destruction.

The dense cortical plates of the mandible, in comparison with other facial bones, result in frequent bilateral fractures — the one at the site of an applied force and the other usually on the other side of the bone due to conducted or indirect force. Consequently the wise physician suspects two when he finds one. This factor of dense bone leads us directly to two other important considerations in the care of a patient with injury to the mandible.

If our patient's fractures result in a free anterior segment, the tongue loses its anterior support and easily becomes displaced posteriorly with the help of suprahyoid muscles to occlude the airway. This is an additionally endangering factor to a patent airway for the injury usually has already supplied a quantity of blood, mucus, and tooth fragments.

The very density of mandibular bone also makes it an excellent piston rod to conduct the applied force from a fist, steering wheel, or blunt instrument to its articular surface supplied by the temporal bone at the base of the skull. The result may vary from a cerebral concussion to a basalar skull fracture with laceration of the brain.

The etiology is as simple as the clinical problem may be complex. The one word "violence" should suffice whether it be applied to a fall, brawl, auto accident, or other blow to the mandible.

The diagnosis should be far from difficult, as a history of trauma, (barring pathologic fractures) pain, tenderness, loss of function, deformity, and crepitus if you wish, invariably are present. X-ray confirmation and identification of secondary fracture lines are necessary to well planned treatment.

Any area of the mandible may be fractured. Certain areas are more commonly affected, for perfectly logical reasons. The most commonly seen fracture is in the region of the mental foramen. This area is exposed and sought for the "knockout" wallop. In addition to local weakening by the presence of the foramen it is remarkably close to the large alveolus of the lower cuspid tooth. The areas of secondary frequency are at the angle of the mandible where a direct thrust force is asked to turn a corner and refuses, and at the surgical neck of the condyle which is the thinnest part of the bone and the one least able to resist a posterior thrust. The coronoid process, nestling behind the protective cover of the zygomatic arch, is the segment least frequently involved by fracture although its friendly buttress takes quite a beating from blows to the side of the head.

It is possible to make a beautifully complete classification of types of fractures of this bone to such sub-sub-sub-head degree as to be useless in establishing a logical plan of treatment. The classification here mentioned is simple and practical.

Mandibular fractures occur in:

1) The BODY of the bone (with or without teeth).
2) The RAMUS or in the posterior portion of the body leaving an edentulous posterior segment (these are similar problems).
3) The CONDYLAR process.
4) The CORONOID process.

Any or all of these may be simple, comminuted, or compound and any can result in fracture with or without displacement.

TREATMENT

Initial or emergency treatment may and usually should precede a final and exact diagnosis as to multiplicity and exact locations of fracture lines. Support of circulation and respiration must always be the first consideration in any traumatic case or other surgical emergency. Clearing of the airway by removal of debris, anterior support of a tongue bearing segment, arrest of hemorrhage (although rare), and thorough treatment of shock must come first.

Careful examination for central nervous system lesions as well as inspection of ear and nasal apertures for possible drainage of cerebrospinal fluid also antedates local treatment. If the sensorium is depressed or localizing neurologic signs of injury are evident, local care must be deferred pending their resolution.

Because of the frequency of compound fractures of the mandible and the common finding of pathogenic organisms about the teeth, adequate treatment requires administration of antibiotics as indicated.

Only when all this has been accomplished can we seriously devote our attention to local care of the lesion and to debridement and repair of such soft tissue lacerations as may be present. These two problems occurred together and should be treated together. It is particularly exasperating to see a patient with neatly sutured lacerations whose now projected bony repair will require removal of sutures placed with loving care.

What are the aims in treatment of such fractures? They must be more than just to make the patient whole again. The means of such accomplishment may not justify the end in the patient's eyes. From this bifocal point of view the aims of local treatment of fractures of the mandible may be listed as:

a) REDUCTION and IMMOBILIZATION of fracture fragments with the teeth, if any, in occlusion.

b) The best method in treatment of mandibular fractures, the method most free of objectionable complications, is generally the simplest method which achieves anatomic and physiologic pre-injury states.

c) With due consideration for the other half of the team, our method of treatment should be the most comfortable for the patient.

d) Our choice of treatment should allow the patient his earliest return to normal or near normal activity.

e) Our treatment should be chosen to spare soft tissues unnecessary and avoidable injury.

METHODS

A number of methods are available to apply these aims to the problem of fractures of the mandible. Those most frequently considered are:

a) Intermaxillary wiring
b) Open reduction and fixation
c) Circumferential wiring
d) External pin fixation
e) Cast or molded splints
f) Intramedullary rods
g) Orthodontic appliances
h) Gunning splints.

Almost any mandibular fracture can be placed and held in good apposition by one of the first two methods listed. These are the two methods most commonly used in successful treatment.

The intermaxillary wiring method requires a near normal complement of teeth for satisfactory application, and in the age range where fractures are most common, enough teeth are present. By this method, the teeth may be used as handles to control fragments and thus overcome displacing muscular action. It is evident that if teeth of the two dental arches are returned to their pre-injury relationships, the bony fragments which bear these teeth also will be properly positioned. A previous reference to dental occlusion comes to focus here. Dental educators have great difficulty in defining exactly the ideal dental occlusion at rest and in various positions of function. Our problem here is much more simple. We wish to use the maxillary dental arch only as a splint for the fractured lower arch. To do so, it is necessary to remember that with a normal or near normal dentition, the lower teeth lie one-half a cuspal eminence lingual and one-half a cuspal eminence mesial (i.e. toward the anterior midline in the line of arch) to the corresponding upper teeth. It is readily seen that this allows them to interdigitate. This is a contact position which the teeth assume normally only in the act of swallowing. Severe malocclusion of teeth and disturbed jaw relationships of the pre-injury state must be recognized before application of this treatment. This method is particularly effective for the treatment of fractures of the tooth-bearing body of the mandible and to insure rest for fractures of the ramus, coronoid process and condyle if there is no displacement of fragments.

Open reduction and fixation by direct osseous wiring or plating is an excellent method for use

in fractures of the edentulous mandibular body, especially when the posterior segment is strongly displaced upward and outward by the pull of the masseter muscle. Many complex methods have been devised for control of the edentulous posterior segment of the body of the bone. None gives better results than this and few give such complete control. This method also is a demand for fracture-displacement of the condyle in children if survival of the growth center is to be possible.

Circumferential wiring is a time honored and effective method in which the patient's lower denture or a similar splint is wired to rest on the edentulous ridge. The wires are passed via a trocar and canula or long, curved needle to embrace the splint and mandibular body on either side of the fracture line. The fracture is then manually reduced and the wires twisted tight to maintain the reduction.

External pin fixation with Stader or Roger Anderson type pins has had a vogue which seems to be on the wane. It allows motion of the joint, and a soft diet which are definite advantages, but it necessitates three or four stab wounds (bearing the pins) and these wounds communicate with bone marrow — a worrisome state for a period of four to six weeks. Those who use this method most enthusiastically have "never seen osteomyelitis result." We had that complication; we've been burned once. The method is applicable to any and all mandibular fractures and though it is generally comfortable and allows early return to activity, it is hardly simple nor does it spare soft tissues.

Cast or molded splints to fit teeth are difficult to construct, are complex to design, delay early treatment, and require much special dental training and knowledge. The same is true of orthodontic appliances and both are limited in their usefulness to fractures of the dentulous mandibular body.

The Gunning splint, consisting of two dummy dentures joined together, enjoyed a vogue for a time in treatment of fractures of the edentulous mandibular body. It bore troughs for the mandibular and maxillary ridges. In application, it was slipped into the mouth, the fragments were manually reduced and a modified Barton head bandage was applied. Although this is a simple enough method of treatment it has an annoying complication of pressure necrosis of the tissues of the bony ridge adjoining the site of fracture.

Intramedullary rods have been used in the mandible, usually in cases of upward and outward displaced posterior edentulous fragment due to fracture anterior to the mandibular angle. Placement is extremely difficult due to the thin posterior border of the ramus just above the angle. Coupled with the thick cortical plates in the area there is little medullary space available.

Once adequate reduction and fixation has been achieved, immobilization must be maintained for an average of four and one-half to seven weeks. During this period, diet must be limited to liquids or extremely soft foods and dietary supplements, particularly vitamin C. X-ray confirmation of fragment apposition is a requirement of present day practice, but clinical evidence of union is all that is necessary for completion of treatment. There will be no X-ray evidence of union until eight to 12 weeks, in the average case.

CONCLUSION

1) It has been suggested that this subject is being neglected in current fracture literature.
2) The total problem of mandibular fractures has been considered from the viewpoint of the specific peculiarities of form, function, and anatomic position of this bone.
3) A simple working classification of fractures, together with some ideas of frequency and bilaterallity of such fractures, has been considered.
4) Treatment of the total patient with a fracture of the mandible has been presented in what the author considers a safe and orderly sequence.
5) A quasi-philosophic presentation of the local treatment of mandibular fractures with special reference to aims of treatment and methods has been presented.
6) Methods of local treatment in reduction and fixation have been reviewed in the light of suggested aims of treatment.

Jaundice in the Newborn

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A HIGH level of bile pigment in the blood, from whatever cause, may be accompanied by injury to the brain of the neonate. Therefore, jaundice in the newborn is potentially dangerous and the earlier it occurs the greater the potential danger. It is not known whether it is the indirect reacting bilirubin itself that injures the nerve cells of the brain or some mechanism associated with the hyperbilirubinemia. But is is known that levels above 15 to 20 mg % of indirect reacting bilirubin in the serum often is associated with the development of kernicterus in newborn babies; conversely, the prevention of hyperbilirubinemia by exchange transfusion also prevents the development of kernicterus. Those of us who are charged with the care of the newborn have a mandate to detect early neonatal jaundice and to prevent the development of hyperbilirubinemia.

The basic factors in the production of jaundice at any age are: excessive destruction of red blood cells, injury to liver cells, and obstruction to outflow of bile. The underlying mechanisms that bring one or the other of these basic factors into operation with such entities as erythroblastosis, sepsis, or atresia of the bile ducts are well understood. The occasional occurrence in infants of other known entities that more commonly cause jaundice in adults also is well known. But when all of the entities within these categories are considered, there remains a large group of uncertain etiology. Included are cases that still are called physiological jaundice and a group collected under the designation, hepatitis.

Although the prime consideration so far as protection of the brain is concerned is the prevention of hyperbilirubinemia (this is accomplished by exchange transfusion), differential diagnosis also is necessary in order that specific therapy, when indicated, may be instituted.

Differential diagnosis may be difficult because: (1) the hepatocellular types of jaundice in an infant may present themselves with signs suggesting complete obstruction, including pale stools and absence of urobilinogen in the urine; (2) hemolytic jaundice cases may be complicated by obstructive features; and (3) liver function tests are of doubtful value in an infant. Nevertheless, it is the exceptional case, rather than the usual one in which an accurate diagnosis, upon which therapy may be founded, cannot be reached.

The relative frequency of occurrence of the various entities resulting in early neonatal jaundice is a changing one. Syphilis, once a prominent cause is now rare. Obstruction due to congenital atresia, once confused frequently and still confused occasionally with jaundice due to sepsis, erythroblastosis, or viral hepatitis, is unusual in occurrence. If one were to list the entities according to the frequency with which they cause neonatal jaundice it would go something like this:

Physiological jaundice
Hemolytic disease of the newborn
Sepsis neonatorum
Hepatitis
Obstructive jaundice
  Atresia
  Plugging of ducts
Others

Sepsis is so common it could well be increased in frequency in many localities with hemolytic disease of the newborn. Also whether hepatitis or atresia is more frequent might well depend upon case material.

Physiological jaundice perhaps should not be included in the list since it usually is regarded as innocuous. But it is not entirely benign as evidenced by the demonstration of kernicterus in premature babies with severe physiological jaundice.[1] Also, a knowledge of factual information concerning the physiological form helps in understanding the problems presented by some of the other forms. In this paper these facts can only be tabulated:

1. The liver is functionally immature. It

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excretes bile at a rate of only 1 to 2% of the adult liver[1] Physiological involution of the liver due to loss of arterial blood from the umbilical veins may play an important part in this immaturity of function but this is not proved.[3]

2. Although only three times normal amounts of bilirubin are formed during the first 10 days of life,[4] the immature liver is unable to excrete it fast enough to prevent indirect reacting hyperbilirubinemia.

3. The more immature the baby, the higher the bilirubin in the blood. Mature babies often reach 7 mg./100 ml. while premature babies often have levels of 12 mg./100 ml.[5]

During the immediate postnatal period the liver is presented with an increased load of bilirubin due to the rapid breakdown of red blood cells. The liver often is unable to clear the plasma of this excess and this defective function is directly related to the degree of immaturity of the infant. Though jaundice usually is of no clinical significance, the term physiological is inaccurate and falsely implies complete innocence.

The cause of jaundice in erythroblastosis fetalis is the greatly increased destruction of red blood cells that have been damaged by the coating antibody. These infants are not jaundiced at birth because the mother has excreted the excess of bilirubin. It is in this group that a close watch for the appearance of jaundice is necessary if kernicterus is to be prevented. Icterus often appears within the first few hours. In our experience at Denver Children's Hospital, level of 5 or 6 mg./100 ml. of serum and sometimes higher were reached before skin jaundice could be seen. The earlier jaundice appears the higher the bilirubin level is apt to go.

If the level is at 4 mg./100 ml. in the cord blood or reaches 6 mg. at 4 hours of age or 10 mg. at 12 hours of age, exchange transfusion should be performed without delay. There is good evidence that the cases in which more than one exchange is required are those in which procrastination or delay for other reasons has occurred. Frequently, when delay occurs after the indications for exchange are present, an obstructive component develops; the stools lose their color, bile appears in the urine, and bilirubin in the blood shows a rise in the direct reacting fraction. The jaundice may then last for three or more months, eventually clearing in most cases, and leaving an undamaged liver.

The livers of babies who have died during this obstructive period show inspissation of bile — so-called bile thrombi in the bile conaliculi of the liver. These cases, not infrequently, are misdiagnosed as cases of congenital atresia of the bile ducts during this period. This complication rarely is a factor during the critical first day of life but after the first day the serum bilirubin should be determined as both direct and indirect reacting forms. Should the indirect component approach 20 mg./ml. in a mature baby or 15 mg./ml. in a premature baby at any time during the first week of life, exchange transfusion can be carried out. The human brain gradually loses its susceptibility to damage during jaundice but the age at which this occurs is not known and probably isn't constant. Limiting exchange transfusion therapy for hyperbilirubinemia of indirect type to the first week of life is purely arbitrary. But it is practical because the liver at the end of the first week is showing more maturity of function and hyperbilirubinemia of the indirect form, above 20 mg./100 ml. is unusual after the first week.

Sepsis of the newborn should always be suspected in cases of neonatal jaundice when the Coombs test is negative. Jaundice from this cause usually is a little more tardy in its appearance than jaundice due to isoimmunization. The organism commonly at fault is E. coli and the portal of entry usually is the umbilicus. Transported through the umbilical veins, the liver is the organ of first localization. These infants may show few or no signs of infection. Since there may be no reminder in the form of symptoms, it must be kept in mind in the differential diagnosis. Sepsis is of equal importance with isoimmunization, with which it also vies as a cause of kernicterus.

Obstructive jaundice is uncommon in the newborn. When it occurs it is usually due to congenital stenosis or atresia of the bile ducts. The anomaly may exist either in the extra or intrahepatic duct system. Even when it is extrahepatic, only a small percentage have sufficient patent duct outside of the liver to allow of surgical correction. Only 16 to 18 percent of cases have anomalies that are theoretically subject to anastomotic surgery and only 5 to 8 per

cent have been cured by surgical procedures.[6] This rate may improve with experience and development of new procedures but, in any case, the condition is important in differential diagnosis. About 15 per cent of cases of prolonged jaundice of the newborn are due to erythroblastosis fetalis, complicated by the inspissated bile syndrome. About half of these have been mistaken for atresia of the bile ducts. Atresia of the bile ducts is difficult to diagnose and must be made by exclusion. Sepsis of the newborn and hepatitis make up another group frequently mistaken for atresia. Isoimmunization, sepsis and hepatitis must be thought of and excluded before the diagnosis of atresia is made.

The term inspissated bile syndrome, used first to indicate the condition resulting from plugging of small bile canaliculi in the liver with bile pigment as a complication of erythroblastosis, is now used by the surgeons also but not to designate the same pathological entity. They use it in relation to plugging of the extrahepatic bile duct system with bile stained mucous plugs. Whether or not the latter is an entity remains to be proved but in any case the two meanings of the phrase must be kept in mind when pediatric or medical and surgical consultants confer.

Infectious hepatitis (virus A) is a rare complication of pregnancy.[7] In the cases in which it has occurred the infants have not been affected.[8] On the other hand, the virus of serum hepatitis (virus B) occurs in the serum of 0.2 to 0.5 per cent of the population and Stokes and associates[9] have shown that transplacental transfer of serum hepatitis from an apparently normal mother to the fetus may occur. Their case is well documented. The serum of the mother and the baby produced hepatitis when injected into human volunteers. The baby was born by cesarean section and was bottlefed; therefore, he was not infected in the birth canal or by transmission through breast milk. The mother gave no history of jaundice.

This baby was one of 12 infants in whom jaundice began shortly after birth. All of these infants showed the same changes when examined at necropsy. The changes in the liver were those described by other authors as giant cell hepatitis.[10] Eight additional cases with similar findings are described by Bowden and Donohue.[2] It may be concluded that giant cell hepatitis may result from transplacental transfer of the A & B viruses of hepatitis. The family incidence of giant cell hepatitis, it has been suggested,[11] may be on basis of carrier mothers. Whether or not giant cell hepatitis is a nonspecific reaction to injury by the infantile liver and may have additional causes, remains to be elucidated. It is a definite morphological entity and can be caused by viruses A & B but it is not yet clear whether or not it represents a single disease process.

Hepatitis in infants may be caused by other known viruses. The virus of herpes simplex [12, 13] and that of cytomegalic inclusion disease [14] belong in this category. Protozoa are represented as causes of neonatal jaundice by the toxoplasma.[15] This is a congenital disease resulting from transplacental transfer from a carrier mother. Though rare, more and more cases are being recognized.

Hemolytic anemia other than hemolytic disease of the newborn may be operative soon after birth. Congenital spherocytosis belongs in this category and it should not be thought of as excessively rare. Though we realize it is an unusual experience, the Denver Children's Hospital staff has treated six newborn babies suffering from hemolytic crises of this disease during the past year. Three of these babies required six exchange transfusions.

Acquired hemolytic anemia also is seen occasionally in the neonate. This disease is on the basis of an autoimmune mechanism as distinguished from the isoimmunization process operative in hemolytic disease of the newborn. These cases may require exchange transfusion to prevent brain injury, in addition to steroid therapy and splenectomy when indicated.

Congenital non-spherocytic hemolytic anemia is an entity that may manifest itself at birth. We have studied a pair of twins, one of which was so affected in the early newborn period and remains jaundiced at age 4. Patients with this disease are not benefited by splenectomy.

Familial nonhemolytic jaundice results from an inherited inability of the liver to excrete bilirubin. When it is manifest immediately after birth the hyperbilirubinemia may result in kernicterus.[16]

SUMMARY

The importance of jaundice in the neonatal period as a potential cause of kernicterus and death is emphasized. Sepsis and erythroblastosis fetalis are presented as the common causes of

jaundice demanding immediate attention in the newborn period. Obstructive jaundice is discussed with notes concerning its medical and surgical aspects. The more unusual causes of jaundice in the newborn which must be dealt with in differential diagnosis are outlined. Physiological jaundice is presented as a phenomenon that is not always benign.

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Disability over 65

It is estimated that in 1950, 5.6 million of the 12 million persons over 65 had some known physical or mental impairment. Such an estimate of the incidence of chronic progressive illness probably is too low. As Steiglitz points out, such data are derived from studies which assume erroneously that chronic disease does not exist unless it is obvious or disabling. Awareness certainly is not a criterion of the existence of a disorder. There probably are more people who are chronically ill and who do not know it than there are those who do know it. Of this group of 5.6 million over 65 with known physical or mental impairment, most are not disabled nor do they have handicaps that call for specialized facilities or services. However, it is estimated that approximately 2.1 million have conditions which will disable them for three months or longer during the ensuing year. In other words, 17 per cent of persons over 65 can be expected to be disabled three months or longer. This is in comparison to 5.8 per cent between the ages of 45 to 64 and 1.3 per cent of those under 45. It is especially for this group of approximately 2.1 million persons over 65 with known chronic progressive diseases, that rehabilitation programs are indicated and so vitally necessary. In the past there has been a defeatist attitude in the treatment of elderly patients with a chronic disease. Often, because of the nature of their disability - hemiplegia, for example - these patients were regarded as hopeless, incurable, irremedial cases. However, a careful distinction must be made between incurable and irremedial. Strictly speaking, there are few medical conditions that are curable and, as people grow older, the difference between incurable and irremedial becomes greater. Most conditions among elderly people are remedial to a certain extent, although at the present time, impossible to cure. *Glen Gullickson, Jr. M.D. and Frederic J. Kottke, M.D. Retaining the Disabled Older Person for Purposeful Living. Geriatrics. Nov.* 1956.

Valued Aids and Essentials in Anorectal Surgery

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THE subject of this paper on valued aids and essentials in pre- and post-operative care in proctologic surgery must by necessity be somewhat cursory and highlighted, since it depends on an established diagnosis and on a proper consideration of the principles of surgery, which in proctology are unique to that specialty. There is danger with such a subject and especially so, if it is published, of its being considered either too cursory on the one hand or too detailed and profound on the other.

PRE-OPERATIVE AIDS IN ANORECTAL SURGERY

Pre-operative preparation should secure a decompressed colon and a clean operative field for surgery. This prepares and safeguards post-operative care including soft and nonpainful elimination. My method is to give five quarts of warm water in an enema on the afternoon and evening preceding surgery and on the morning of surgery. The enema bag should have a well-lubricated No. 20 F. catheter that is inserted only two or three inches intra-anally with the patient in a knee chest position or lateral Sims' position. Pour two ounces of mineral oil down the enema bag or can into the tubing and follow with the quart of water so that the oil may be carried up into the colon, coating and lubricating it.

Pre-operative shaving aids in cleanliness. Sedatives at night and before surgery ease nervous tension and worry. When barbiturates are given they may prevent reactions from novocaine or allied drugs in spinal anesthesia reactions. Dramamine is useful in preventing nausea during or following surgery. Tubocurarine (Tubadil®) before or during surgery encourages prolonged muscle relaxation, reducing painful spasm postoperatively.

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GENERAL RULES GOVERNING PROCTOLOGIC SURGERY

Many frequently stressed points of surgical technique will not be completely covered in this discussion. Certain general points, however, must be mentioned since they are essential and unique to proctologic surgery. Such necessary observances should be considered as laws or principles of anorectal surgery, adapted from the laws or principles of surgery in general. Foremost consideration to successful anorectal surgery is the need for the removal of correction of all diseased or dysfuntioning tissue when final corrective hospital surgery is performed. Palliative minor surgery such as external hemorrhoidectomy of a thrombosed group of hemorrhoids or drainage of an abscess, may precede anorectal surgery. But hemorrhoidectomies, for example, should be complete and should correct redundant or prolapsing tissue and fistulectomies should be accompanied by hemorrhoidectomy when hemorrhoids are present which usually is the case.

Divulsion should never be practiced. Excessive removal of anodermal and mucosal tissue should never occur and adequate room in the anorectal passage is a necessity for proper healing and normal elimination. An elastic expanding and contracting anorectal orifice necessitates meticulous surgery and the transposition of anorectal tissues to their normal anatomical positions or relationships or at least, as nearly so as possible.

GENERAL OPERATIVE AIDS IN ANORECTAL SURGERY

Regardless of the type of surgery, the author finds certain aids exceedingly helpful. First is the immobilization of anal skin by carefully placed fine double or triple 0 silk sutures, preferably atraumatic, which is not painful and does not cause inflammatory reactions. Fine double 0 chromic atraumatic catgut likewise causes no reactions in skin suturing. Both forms of suture

may require removal post-operatively. Silk may be tied snugly to slough out properly thereby avoiding the need of removal. Other forms of suture material may react on tissues and cause inflammatory reactions and pain when used on skin. Furthermore, some cannot be removed easily or painlessly. Atraumatic sutures are always preferable. They should not include muscle fibers but should be placed directionally, paralleling muscle fibers and when so inserted should be tied gently, though properly, so as not to necrose tissue. Tronothane[R] ointment and later, in a spray gives marked relief as a topical post-operative anesthesia. One to 2 cc. oil anesthesia injected into the wound lessens pain.

POST-OPERATIVE AIDS IN ANORECTAL SURGERY

Massive hot wet packs across the buttocks probably give more immediate relief from spasm and pain or discomfort than any other measure pre- or post-operatively. They should be continuous on the day of surgery. Proper pre-operative measures and careful surgery permit the majority of patients to have minimal if any pain following anorectal surgery. The type of surgery, however, may determine whether or not pain or discomfort is present as later more specific considerations will disclose and elaborate.

Morphine and scopolamine on the day of surgery are excellent narcotics. Careful hemostatic surgery allows early ambulation on the day of surgery as an aid to voiding. Initial catheterization and urinary antiseptics are necessary frequently.

Careful pre-operative preparation permits controlled and easy post-operative care. Decompression of the colon pre-operatively, oil retention enemas on the third post-operative day, and inducement of bowel movements on the fourth day prevent discomfort and permit easy normal bowel movement thereafter. A soft bland diet and hydrogels, such as Hydrocil[R] or Metamucil[R], should be given daily following the day of surgery.

Prolonged post-operative care with frequent wound cleansing and visualization are requisites no matter how perfect the surgery and all other factors. Complications are avoided by careful excision and treatment of wound tissues. Pseudo-adenomatous tissue is not infrequent post-operatively and should be removed since it may become adenomatous and pre-cancerous. Post-operative papillae may form and hypertrophy; skin edges may overlap and become post-operative fissures and lead to stricture or stenosis; and granulation tissue — normal to all open wound healing — may become excessive and retard normal epithelialization. Such complications, as well as tags, edema, spasm, and bleeding may be indicative of faulty surgery and technique and may be accompanied by pain. They may be forerunners of further post-operative complications.

Dilatation for the sake of exposure and treatment of painful spasm may be necessary only when such abnormalities develop. The normal post-operative wound, though sensitive, is more relaxed and more painlessly expanded and visualized. Such careful visualization is necessary on occasion after the eighth post-operative day.

The proper care of wounds requires daily meticulous attention by physician, nurse, and orderly while the patient is hospitalized and on leaving, by both physician and the patient. The frequent separation of wound tissues, cleansing of wound parts, and normalcy of bowel action must be maintained. The frequent treatment of wounds safeguards this necessary care. Checkups after healing prevent late complications and regulate established therapy.

SPECIFIC OPERATIVE CONSIDERATIONS

In this paper special aids of value will take into consideration only the treatment of hemorrhoids, abscess, fistula, fissure, and anal stricture since they are more common in anorectal surgery. Only the highlights of these conditions and their valued aids can be discussed. Specific and more comprehensive therapy in hemorrhoids, fissure, abscess, and fistula should be referred to in publications[1,3,4,5,7,8,21] elsewhere.

HEMORRHOIDS

Few proctologists perform identical hemorrhoidectomies and no hemmorrhoidectomies are completely original and distinctive in technique. Ligature, ligature and excision, clamp and cautery, and clamp ligature with excision are employed in varying adaptations in all types of the usual nonradical hemorrhoidectomies. Radical hemorrhoidectomies[6] require some type of plastic procedure and are reserved for severe prolapsing types, as a rule.

The author has avoided radical procedures by

the simple expedient of immobilizing anal skin with carefully placed silk sutures and by a method of multiple, carefully placed, radial internal and external hemorrhoidal clamp ligature. Not long ago I reclassified[2,9,11] all hemorrhoids into primary and secondary hemorrhoids on the basis of their etiologic formation; primary is congenital or acquired venous wall weakness and secondary is due to occlusion or thrombosis in distal or deep collateral circulation. Subtypes in either primary or secondary are internal, mixed, prolapsed or thrombotic as examination may determine. This classification and the knowledge of a profuse collateral blood supply have been helpful in treatment, especially in developing the technique just mentioned of multiple clamp ligature. There is a profuseness of collateral blood supply [10,11,12,13] which is more completely combated in such hemorrhoidectomies, when performed by simultaneous multiple clamp application. This not only renders the procedure — for the greater part, bloodless — but also permits more a rapidly healing, less painful yet complete procedure, when combined with certain additional points of technique. Hemorrhoidectomies may be aided by more frequent use of partial posterior sphincter muscle incision (sphincterotomy) so as to secure more adequate room and relaxation.

ANORECTAL ABSCESS AND FISTULA

Anorectal abcess should always be uncapped and drained as soon as diagnosed. The author long ago discontinued simple incision and drainage and believes elliptical uncapping externally of all abscesses, followed by partial incision into the various rectal fossae and for the most part only blunt dilatation into the abscess, are essential to proper drainage. These wounds lend themselves to subsequent fistulectomy or fistulotomy. As a limited office procedure, incision rather than uncapping may be necessary.

No surgeon should attempt the treatment of anorectal abscess of fistula without a thorough knowledge of the anatomy of the pelvis and rectum. Outstanding contributions on the surgical anatomy are those of Gorsch[14] and Courtney[15]. Courtney[16] properly stresses the drainage of posterior levator space abcess through posterolateral separation of the decussating leaves of the levator ani muscle in its attachment to the longitudinal muscle fibers of the rectum.

Personally, I believe it is a gross error to drain any high supralevator or intramural rectal or submucosal rectal abscess transrectally and have always obtained eventual correction by exteriorized perianal or ischiorectal drainage.

Salient aids to fistulectomy may be summarized by stating that:

1. The primary internal fistulous opening usually is cryptic and even if midanal or from a fissure, still involves the superimposed crypt.
2. The crypt, though primary, invariably involves its component anal duct or anal acinar gland and surgery should carry into the internal sphincter to excise or incise and drain this primarily involved fistulous accompaniment.
3. Exact determination of the primary crypt and cryptic zone is not best done by the injection of dyes but by careful probing inspection, palpation, and exposure. Amputative musosal excision of the primary and adjacent crypts is always done by the author since they may be infected by contiguous inflammation or be primary though not so proved grossly.
4. The amputated mucosa should be transplanted slightly superior to the dentate margin level (anorectal line, pectinate line) after excision of the involved primary crypt and adjacent crypts and following its transverse clamping with a crushing hemorrhoidal clamp.
5. Posterior primary fistulous crypts require partial or complete severance of the external subcutaneous sphincter muscle fibers and corrugator cutis fibers and an open wound into the space of Brick, irrespective of their communicating ramifications.
6. Extensions of fistulous tracts deeply or completely under the external subcutaneous and internal sphincter fibers require the use of a seton. This is not a guide for later constriction and pressure necrosis and severance of sphincter muscle at a tract site; but is a heavy cotton or silk suture threaded under partially severed and remaining fibers for later deliberate incision. The author later, as an office procedure, anesthetizes locally with novocaine and severs

such tissue with an electrodesiccating cutting cautery.

7. All wounds are saucerized so as to avoid too early external healing and bottle-necking of a wound and too early epithelialization; and also so as not to necessitate heavy pressure packing.
8. Most fistulectomies are fistulotomies and the base of the tract may be left as long as a tunnelled tract has been finally converted into an open ditch with an exacting saucerization, so that the final healing epithelialization does not carry into a cleft, but across a broad, smooth, flat area of filled-in healing with clean granulations.
9. All fistulectomies should be accompanied by removal of all other diseased tissues and should include complete hemorrhoidectomy.

FISSURE-IN-ANO AND ANAL STENOSIS

Most authors stress that no single operation is a panacea for all types of anorectal pathology. Martin,[17] Carmel[18] and Granet[19] among others have described excellent anorectal plastics, especially applicable for fissure or anal contracture. Belnap[20] has confirmed the merits of Carmel's sliding graft procedure with his own series.

All are agreed, regardless of what technique or procedure is used that all offending pathology should be removed. With any fissure the offending crypt, scar, papillae, and accompanying hemorrhoids must be removed. Anal ducts and glands should be opened or excised.

Many of my own cases[21] are treated by a somewhat modified technique which mobilizes skin and requires excision of offending pathology and a partial posterior sphincter severance. As previously stated, the use of fine silk suture is of great aid, particularly here, where skin must be sutured.

Since fissure and stricture are conditions frequently concomitant and one is prone to form the other, ordinary, nonplastic types of operative procedures too frequently are not successful. Anorectal plastic operations therefore are important to use exception in congenital stenosis or fissure of infancy.

Ease and rapidity of healing, freedom from pain, and a more physiologically normal anorectum are to be had by their use — for the greater part, by reason of a more mechanically normal restoration of epithelium and mucosa in most anorectal plastics.

OTHER ANORECTAL AND PROCTOLOGIC CONDITIONS

A host of proctologic conditions could be considered specifically if this paper were to review exhaustively all phases of anorectal surgery. One should be well versed on the treatment of all colon and rectal disease to handle adequately even the simplest. Just as in abdominal surgery, one must be prepared to recognize or operate any associated or unexpected pathology. Anorectal surgery may be contra-indicated when severe or more important colopathies such as ulcerative colitis, polyposis, or malignancy co-exist. To cite examples of errors: Rectal stricture and anorectal or anal stricture may be confused and require totally different treatment; pilonidal sinus may resemble or be present with anorectal fistula.

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The Diagnosis of Nasal Allergy in Children

PHILIP L. WACHTEL, M.D., FREEPORT

THE most common allergic disease in children is nasal allergy.[1,2,3,4] Yet diagnosis frequently is missed, and, when recognized, the reaction has produced symptoms for more than five years in the majority of cases. In some patients, symptoms have been accepted by parents and children without securing medical attention. In others a variety of treatment has included nose-drops, vitamins, tonsillectomy and adenoidectomy, and X-ray to the nasopharynx; all with little or no relief. In either case the parents have become at least partially reconciled to the notion that Johnnie is "just one of those children who has colds all the time" and to the hope that he'll "outgrow them".

But what happens while a child is trying to "outgrow" his nasal allergy? Infection of the nose and paranasal sinuses is frequent, and with repetition becomes chronic. Simple edema of the mucous membranes is replaced by irreversible hyperplastic and inflammatory changes producing some degree of permanent nasal obstruction. The sinuses become chronically involved, having lost their normal defenses of drainage and ciliary action. Chronic bronchitis and bronchiectasis may be found.

Symptomatic relief can be obtained in many cases, and these complications largely avoided, by proper diagnosis and treatment. Whether or not the subsequent development of asthma, variously estimated to occur in 10 to 50 per cent[5,6,7] of those with nasal allergy, may be similarly avoided is questionable but ought to be determined.

In general, the prevention of allergic disease has proved difficult if not impossible. However, should it be shown that clinical allergy cannot be avoided, at least it may be expected that symptoms will be less severe with proper care. More precise information concerning the outlook for patients with nasal allergy, treated or untreated, will be available only with widespread recognition of its symptoms.

HISTORY

As in other allergic diseases, the history is of foremost importance. The chief complaint is classically of "a cold all winter" or it may seem that the patient "just has a cold all the time". The onset is insidious early in life, often before age 2. The most prominent symptoms usually are nasal obstruction and discharge. This obstruction is more or less constant even when other symptoms are absent. The discharge usually is clear but may be purulent with secondary infection. It may be profuse during acute symp-

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toms, and scanty or entirely absent at other times. Itching of the nose and eyes is the rule, as in seasonal hay fever, and the characteristic rubbing of the nose has been aptly called an "allergic salute". Repeated sneezing is a frequent complaint and occasionally the most prominent symptom. A loose cough may be present. All symptoms generally are worse upon arising.

Seasonal variations occur, depending on the causative allergens, and may lead to diagnosis by the layman. Symptoms due to housedust, the most common offender, typically begin with the onset of winter and clear when the heat is turned off in the spring. If trees, grasses, or weeds are producing the causative agent, symptoms are worse during a particular pollen season or with a change in environment such as a trip to the country. Relief coincides with the well known "trip to the mountains" or "week-end at the seashore".

That the illness is not contagious, is not related to exposure to another case, and is without constitutional symptoms may be of value in the differential diagnosis. However, these characteristics of nasal allergy often are unrecognizable, having been obscured by the presence of secondary infection.

The past history and family history have been positive in 50 to 75 per cent of patients but the percentage of positive histories varies with different methods of collection of data, the readiness of the examiner to accept certain symptoms as allergic in nature, and the extent of inquiry into family incidence of allergy.

PHYSICAL EXAMINATION

The physical diagnosis of nasal allergy requires a thoughtful examination of the upper respiratory tract, and may be difficult in many cases. The nasal mucous membranes are typically pale, boggy, and edematous, covered with a clear, mucoid, watery discharge. However, the nose may appear injected and dry or completely normal. Nasal polyps are rare in children. Pathologic changes similar to those seen in the nose are known to occur in the paranasal sinuses but their diagnosis by physical means is difficult. Transillumination is particularly unrealiable in children due to wide variations in bony thickness and development of the sinuses. In both the nose and sinuses, bacterial invasion can change the entire picture to one of an acute upper respiratory infection, and in some patients this must be treated before signs of the underlying allergy become apparent. The remainder of a complete physical examination will reveal other allergic diseases, notably asthma, in more than 50 per cent of the patients.[8]

LABORATORY EXAMINATIONS

In the laboratory diagnosis of nasal allergy, several tests should be done, but most important is the nasal smear for eosinophils. While other standard procedures may indicate the presence of nasal allergy, the demonstration of a significant degree of nasal eosinophilia is diagnostic. Only by complete elimination procedures and controlled exposure to the offending antigens can a positive diagnosis be made otherwise. The value of the nasal smear was demonstrated by Hansel[9] in 1934 and subsequent observations have confirmed his findings. An occasional eosinophil may by obtained from the nose of normal individuals, but numbers greater than 2 or 3 per cent of the cells present are indicative of allergy, and 10 per cent or more is diagnostic. Up to 50 per cent or more has been observed. It must be remembered though that eosinophilia varies widely and at times may disappear, particularly in the presence of an overlying infectious rhinitis. While a single nasal smear will be positive in approximately 70 per cent of cases, negative result may be considered significant only after three examinations made in the absence of secondary infection.

Smears are easily obtained when a profuse discharge is present by having the older child below his nose on waxed paper, from which the material can be transferred to a slide. In an infant, the secretion is sucked out with a common rubber bulb ear syringe. Where the membranes are drier, a cotton applicator may be used and left in the nose for a few minutes if necessary to stimulate secretion. The slide is air dried and then stained by one of several methods. Wright's stain is used by many, and Hansel's Combined Stain for Nasal, Conjunctival, and Bronchial Secretions is said to give good results. Here we have used eosin and methylene blue. The procedure is outlined below.

1. Stain for one minute with eosin solution (2%).

2. Add enough distilled water to pick up the staining solution and to cover the slide completely as in the Wright's technique. Allow to stand for one minute.
3. Drain off and flood with distilled water until all free stain is removed.
4. Flood with 95% ethyl alcohol and drain off.
5. Then immediately stain with methylene blue solution (1-100) for one minute.
6. Add distilled water to cover slides as above and let stand for two minutes.
7. Remove excess stain with distilled water and finally, the ethyl alcohol as above.

If the neutrophils do not stain well, restain with methylene blue as above.

The cytoplasm of the eosinophils will stain a brilliant red with easily recognizable granules, and the nucleus will stain blue. The neutrophils and epithelial cells will stain with a deep blue nucleus and a lighter blue cytoplasm. However, if the secretion is thick and tenacious, and there are large numbers of neutrophils, they may not stain completely. In this case they may show a slight pink color and should not be mistaken for eosinophils.

The total white count is of value in determining the presence or absence of infection. In the differential blood count a moderate eosinophilia may indicate allergy, but it must be kept in mind that the percentage of circulating eosinophils is variable and has no relationship to the severity of the disease. Eosinophilia is particularly likely to disappear during an acute infection, reappearing as it subsides.

A serological test for syphilis is imperative, since lues may mimic the nasal obstruction and discharge of allergy.[10]

The sedimentation rate in allergy is perhaps even lower than the average normal.[11] Among patients with nasal complaints, an elevated sedimentation rate is good evidence of infection even though other diagnostic techniques have failed to reveal its presence.[12]

Nasal cultures are obtained in an attempt to identify an infecting organism if present.[13]

X-RAY DIAGNOSIS

Following these laboratory procedures X-rays are taken of the chest and sinuses even though the positive value of such films frequently is questionable. Chest X-ray may be expected to show only nonspecific increase in peribronchial markings and while sinus changes are frequently seen[14] they are almost equally as common in apparently normal individuals.[15,16] It may be felt that a definite diagnosis could be made by naming the type of pathological process appearing on sinus films but attempts to do this have proved hazardous. However, after considering these limitations, one fact of positive importance remains. Allergy tends to involve all the sinuses equally, and X-ray diagnosis of pansinusitis correlated with clinical findings is probably significant.

SKIN TESTS

Having completed the history as well as physical and laboratory examinations, skin testing is done to substantiate a diagnosis of allergy and to identify the causative agent or agents. The positive skin test does not always mean clinical allergy but in nasal allergy, multiple clinically significant positive skin tests are the rule. Inhalant reactions are usually demonstrated, with house-dust a prime offender[17, 18] and pollens second on the list of causative allergens. Food allergies are less important and a positive skin test is not considered significant unless closely correlated with the history or with elimination diets and controlled ingestion.

The specificity of positive reactions in infants compares favorably with that in the older child. Since foods are the most important allergens in the young infant, and skin tests for food allergy are unreliable at any age, it must be admitted that infant skin testing may be of little value. However, the frequent inability to demonstrate skin reactions to many substances does not mean that the infant skin is incapable of an antigen-antibody reaction. That it can react with erythema and whealing has been shown.[19] When we realize that massive or repeated exposure usually is necessary to produce sensitivity, it is only reasonable to expect that substances foreign to a baby's environment will give few positive skin tests. An infant who has never been through a ragweed pollen season is not likely to have a positive skin reaction to ragweed, but this does not mean that he cannot react to one or more of the common baby foods.

Skin testing may be done by the scratch or

intradermal method, and neither should be used to the complete exclusion of the other. However, if one is to be used alone or as a routine procedure, especially in children, scratch testing is the method of choice. The sensitivity of the scratch test may, depending on the strength of solutions used, be less than with intradermal injections, but if so the incidence of pseudo-reactions will be likewise reduced. Where indicated intracutaneous or intradermal tests should be used after the scratch to confirm or deny questionable results. Intradermal testing done without the preliminary scratches has caused death.[20]

Other indicators of hypersensitivity such as the ophthalmic or inhalation tests also have been used in the diagnosis of inhalant allergies, but are seldom necessary.

CASE REPORT

The following case from among those seen at Milwaukee Children's Hospital Out-Patient Clinic is presented to illustrate the application of the forementioned diagnostic techniques.

A 12 year old boy was first seen in October, 1955 when he entered with a chief complaint of "nose trouble" for the past eight years. It consisted of continual nasal congestion with intermittent nasal discharge, sneezing, and cough. Though perennial, these symptoms were most severe during the winter. Constitutional symptoms were absent. Treatment consisted mainly of nosedrops and antibiotics. In 1948, X-ray therapy was applied to the nasopharynx with the usual transient results. The past history was significant with one episode of wheezing diagnosed as asthma in 1953. The family history revealed that the patient's father also had frequent "colds" and "sinus trouble" characterized by headaches and nasal congestion and discharge.

On physical examination the nasal mucous membranes were slightly injected without gross edema. There was a scanty, thin, mucoid nasal discharge. The skin and lungs were clear.

The white blood count was 13,500 with 50 per cent neutrophils and 7 per cent eosinophils. The urinalysis and Kline were negative. The sedimentation rate was 9 mm./hour (Westergren). Nasal culture revealed no significant pathogens. The chest X-ray was normal. Sinus films showed considerable mucosal thickening in both antra. Less than 1 per cent eosinophils could be demonstrated on the first nasal smear: on the second, approximately 35 per cent was found. Scratch tests showed a 4 plus reaction to house dust with lesser reactions to feathers, cattle dander, grasses, and weeds. All foods tested gave negative results.

The patient was considered to have nasal allergy due primarily to house dust, and is currently under treatment at the Milwaukee Children's Hospital Allergy Clinic.

COMMENT

Nasal allergy, variously termed allergic rhinitis, allergic coryza, paroxysmal rhinorrhea, catarrhal rhinitis, perennial hay fever, and vasomotor rhinitis is common. An early diagnosis can be made using only those procedures outlined above. This is the first step toward a gratifying partial or complete relief of symptoms, and it is hoped toward the prevention of more disabling allergic disease.

SUMMARY

The most prevalent of childhood allergic diseases, nasal allergy, is frequently undiagnosed; its symptoms are mistakenly attributed to the common cold or a primary bacterial URI. If treatment is to be successful in alleviation of symptoms, prevention of complications, and avoidance of other allergic diseases, an accurate diagnosis must be made, based upon the history, physical findings, laboratory examinations, X-rays, and skin testing procedures.

The history is typically of long standing nasal obstruction, nasal discharge, itching of the nose and eyes, sneezing, and cough. The severity of these symptoms varies with environmental and seasonal changes.

Physical findings in the nose vary widely. Classically, the mucus membranes are pale and edematous, covered with a clear, watery discharge, but they may appear normal or reveal only signs of secondary infection.

Of foremost importance among the required laboratory tests is the nasal smear for eosinophils. A method of staining these smears with eosin and methylene blue is outlined. Nasal eosinophilia of 10 per cent or more is diagnostic of allergy and with repeated examinations, will be found in more than 95 per cent of cases.

Other useful laboratory procedures include the white and differential blood counts, a serological test for syphilis, the sedimentation rate, and nasal cultures.

X-rays of the chest and nasal sinuses are of limited value.

Skin testing should be done in both infants and children, and will reveal multiple clinically significant inhalant sensitivities in more than 3 out of 4 patients.

A case is presented to illustrate the applica-

tion of these diagnostic measures.

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Comprehensive medicine

What, then, is to be gained from taking the student out of the teaching hospital into the home for a portion of his clinical training? It seems to me that the gain is primarily in the practical sphere and that it is, in a sense, killing the goose that may lay the golden egg. Even if the intent is to turn out better general practitioners, a perfectly good case may be made for the view that it does just the opposite. If this is true, the preceptor himself can hardly be blamed. His professional life usually is a full one, and it seems unreasonable to expect that he can or will take the many extra hours necessary to teach as well as to practice. So far as training in the home is concerned, I question its value primarily because it seems inefficient. Kitchen table surgery, for example, will surely find few supporters in this country at the present time. While there is some truth in the contention that work-ups in teaching hospitals are sometimes unnecessarily elaborate, the teaching value of such work-ups cannot be fairly compared with that of the shortcut variety so frequently necessitated by conditions in the home. If shortcuts must be learned, the medical school is an inappropriate stage at which to introduce them. Neither is it an appropriate stage at which to begin the vital process of making a human being out of a student. If he is not honest, sympathetic, and well integrated when he enters medical school, he is unlikely to be all these things when he leaves. The inescapable responsibility of the medical school is to make medical scientists out of the best student material it can get. And in the rush to make students into paragons of universal understanding and accomplisment, the main responsibility is becoming obscured. *Carleton B. Chapman. On the Teaching of the Science of Medicine. Clin. Res. Proc. Sept.* 1956.

Carbon Dioxide as a Useful Tool in the Treatment of Neurotic Disturbances

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AT a time when the scientific world is eagerly engaged in the investigation of new chemical agents useful in the treatment of the major psychoses, it may appear blasphemy to speak about the relatively small group of patients with a neurotic personality pattern who ultimately find their way into the large mental hospitals. There they are generally out of place, barely tolerated, and often get "lost" among the great number of psychiatrically much sicker patients. However, those persons with a neurotic personality pattern who finally do find their way into the state hospitals, whether on commitment or on a voluntary basis, are usually rather ill in their own way. They generally have exhausted all the extramural help available as well as their relatives' financial resources. Nevertheless, they are a group of patients, who with some concerted action can be rehabilitated sufficiently, so that their discharge from the hospital can materialize. In this paper we will concern ourselves mainly with one of the various tools available to the professional man trying to rehabilitate such patients — namely, carbon dioxide.

The investigation was done during the time [from July 1951 to August 1953] I was on the staff of the Oregon State Hospital in Salem, Oregon. Having become interested in carbon dioxide after reading Dr. Liests' stimulating "Personality Mutations Following Carbon Dioxide Inhilations", we perused the literature concerning the reaction of other investigators. This paper will not concern itself with the neurophysiological or neurochemical aspects of carbon dioxide inhalations, nor about the various theories evolved concerning the modus operandi of its therapeutic mechanism. Those interested are referred to Dr. Meduna's excellent monograph on the subject. We shall contain ourselves to describe the treatment method and the results, taking as the criterion for improvement the social recovery of the patient. A person whose neurotic adjustment was so severe that he or she could no longer be treated by a physician on an outpatient basis had to seek hospitalization in a State institution, then improved sufficiently that a discharge from the hospital could materialize. While in the service we fortunately had been stationed near the west coast for the two post-treatment years. Thus we were able to keep in touch with a great number of patients and their relatives. Periodic visits to the Salem hospital kept us informed about the rehospitalization of some of the patients reported in this paper. It is realized that a lack of necessity to return to that particular hospital does not prevent a patient from being hospitalized elsewhere. There is no dead sure criterion that those who did not return during the two years of follow-up may not also relapse in due time. Most of those originally hospitalized were residents of Oregon with their permanent homes in said locality. Some follow-up observations and conclusions may be drawn about the efficacy and stability of their reactions to the treatments.

Presented before the Physicians Association, Dept. of Public Welfare, 116th Annual Meeting of Illinois State Medical Society, May 15-18, 1956.

METHOD

The majority of patients were treated with the 70% oxygen and 30% carbon dioxide mixture commercially available. The apparatus used consisted of the standard tank outlet, breathing bag with multiple masks customarily used and described by other investigators. The patient was placed on a couch with a large blanket about the body. The nurse assisting in the treatment would sit on the back folded blanket, thus providing stability to the treatment situation and preventing the patient from leaving the treatment couch prematurely. She would hold the patients' hands lightly providing

reassurance to the patient and stopping him from dislodging the mask. At first the patients remained dressed, but as there were not infrequently urinary "accidents" the patients were later on dressed in hospital gowns. The author believes that a thorough physical examination is highly therapeutic. All patients received such an examination as well as the customary dental check, chest X-ray, urinalysis and blood count prior to commencing the treatments. Any physical deviations found were corrected before the treatment was started. All patients were frankly informed that we concur with the opinion of their previous doctors that their present difficulty must be of nervous origin, inasmuch as no gross organic pathology has been found. They were informed that we would try to utilize a treatment procedure successfully employed by other investigators. No binding statements as to possible results were made. In general they were "won over" to accept the treatment. Once having signed for it they were not allowed to back out, unless they became worse by the treatment or on their own left the hospital in accordance with their status as a voluntary patient. Several of these returned later on and a few of them took the treatment to a successful conclusion. Others needed the persuasion of their relatives and outlook of a possible commitment to return to the hospital. The individual treatment took only a few minutes, the number of inhalations varying from a few at the beginning of the series to 60 or even 80 at the end of the series. Patients' needs often changed from treatment to treatment, and several exhibited a certain tolerance. Generally the patients were brought down to the "unconscious" level. This was more a state of altered consciousness, as many patients related horrible dreams that they had experienced during the time they were "clinically unconscious". Several patients were brought down to the convulsive level and no adverse post-treatment effect could be observed. Any verbal productivity or utterances made by the patient while under treatment were carefully noted and later on made the center of discussion. As soon as the patient had regained full consciousness the assistant would leave the room. The patient was then permitted to talk for a few minutes about anything that came to his mind. When time was pressing this step would be omitted and the patient was encouraged to write down whatever thoughts came to his mind. This would be discussed at the next interview session. Patients received two treatments weekly with an interview session of about 45 minutes. The latter was sometimes substituted for a third treatment. The maximum number of treatments given to any one patient was 50. Because of lack of space patients not being well enough to leave had to be rotated through the hospital or channeled to a more appropriate ward in accordance with clinical development.

RESULTS

Carbon dioxide was given also to 2 male patients, and many treatments were given on an experimental basis to known psychotics, mainly catatonic schizophrenics. This report primarily deals with 86 white female patients afflicted with a neurotic personality pattern, ranging from 25 to 45 years age. There were in addition 2 youngsters of 15 and 17 years of age, transfers from the girls' correctional school.

The clinical symptomatology of some of the patients was so diverse that more than one diagnostic label could have been attached. Adherence to a symptomatic description of patient the main difficulty will suffice and give information concerning the type treated. (Table 1, page 245)

DISCUSSION

Most of the patients complained of a feeling of choking or strangulation, which could not always be attributed to the gas mixture used. Others had disturbing dreams; some had sex dreams. Although all were given the opportunity to satisfy their physiological urges prior to commencing treatment, urinary accidents were not infrequent among our patients. In our series we were most successful with anxiety reactions and least successful with alcoholics. While carbon dioxide did not cure any of the group listed as pseudoneurotic schizophrenics it at least aided in clarifying their position and thus enabled us to channel them to the proper treatment ward. This did not permit them to continue keeping their "fence holding" position as they had done for many years. While we had little success with the group listed under "miscellaneous" the small number of each subgroup available does not lend itself to draw final conclusions about the efficacy of carbon dioxide treatments in that group. It is quite likely that other investigators with a

TABLE 1

Anxiety Reactions:		
Improved, left hospital	28	40
Improved, left hospital and relapsed	3	Total No. Treated
Left before 5 treatments unimproved	5	
Stopped before 5 treatments	3	
Improved, returned to Girls' School	1	
Pseudoneurotic Schizophrenics:		6
All had less than 10 treatments, and subsequently Insulin and Electric Shock. One had Metrazol. All are home, but only 2 are productive.		
Alcoholism:		13
Left hospital improved	13	
Returned to hospital	11	
Hysteria:		3
Left hospital improved but returned	1	
Obsessive Compulsive:		3
Left hospital improved	2	
Anxiety Masking An Involutional Syndrome:		1
Patient did not improve but responded well to EST, as one would expect.		

Miscellaneous:		
Character neurosis with drug addiction	treated 4	improved 0
Character neurosis with stealing	treated 2	improved 0
Asocial personality	treated 2	improved 0
Conversion reaction	treated 2	improved 0
Exhibitionism	treated 1	improved 0
Hypochondriasis	treated 2	improved 0
Neurasthenia	treated 3	improved 0
Nymphomania	treated 2	improved 0
Passive aggressive personality	treated 1	improved 0
Phobias (Car and height)	treated 2	improved 0
Severe anxiety in a hypothyroid with a surgical menopause	treated 1	improved 1
Total number	treated 22	improved 1
Overall No. of patients in this series:	88	

Improvements:

Anxiety reactions	29	
Alcoholism	2	
Obsessive compulsive	2	
Miscellaneous	1	Total 34 or 38½% of total, but about 80% of 10 Anxiety reactions.

greater number of patients of each subgroup may be able to report more encouraging findings. We did utilize mild supportive psychotherapy with all our patients yet feel that the treatment effect is due to the gas mixture used. Practically all of the patients had had psychotherapy at one time or another during their prehospitalization days.

SUMMARY AND CONCLUSIONS

Carbon dioxide treatments were given at the Oregon State Hospital in Salem, Oregon to a group of 88 white female patients of various ages, all exhibiting a neurotic personality pattern. The treatment was found to be most encouraging with anxiety reactions and least encouraging with alcoholics. The gas mixture is not to be thought of as a panacea for all psychiatric ailments, yet it is felt that it can be one of the useful tools available in the treatment of nervous disorders. As most of the patients were found to be rather noisy and vociferous during the treatment it is advisable to administer this form of treatment in hospital environment.

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Abstract

The Importance of the Family Doctor in Psychotherapy

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With rapid scientific advances our knowledge of etiology of disease has led us to standardization of treatment. The management of diseases of known etiology can easily be learned. The knowledge of which drug to use is seldom a difficult skill for a doctor to acquire. Today doctors handle disease competently.

Unfortunately I cannot say that doctors always handle patients as competently. Here we enter a field in which there is little standardization and seldom any formal training.

The growth of the various specialty boards, necessary as they were to establish high standards of training and professional specialized skills, resulted inevitably in a shift of emphasis away from the patient. This was necessary if limited special interests were to be studied intensively and special skills were to be acquired. The desire of doctors to limit their endeavors to a particular specialty or sub-specialty also may result in limiting their usefulness. The more specialized a doctor's training becomes, the greater the opportunity for him to develop distortions in his point of view. Each doctor views his patient from a different perspective. . . . . .

The emphasis too long has been placed on diagnosis rather than on treatment. A danger which a patient risks today when he consults a physician is the danger of being given a diagnosis. Patients must not be "pigeonholed". Too often patients are run through "assembly line" diagnostic mills, are seen by seven different specialists, come out with fourteen different diagnoses and often with conflicting recommendations for treatment. Patients cannot be "sliced up" according to medical specialties and cannot be treated as a collection of diseases. Every specialist has his limitations and the more specialized a specialist he is, the greater his limitations

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become . . . . The more comprehensive our viewpoint, the better job we can do in helping the sick.

The revival of the concept of psychosomatic medicine in recent years has been helpful in a reorientation of physicians as to their aims in the practice of medicine. It is not a specialty, but a point of view . . . . .

To my mind what psychosomatic medicine should represent is the point of view that we again recognize that the patient is not a collection of organs or diseases in one housing, but a complex, integrated psychological as well as physiological and anatomical entity subject to daily stress and constant change. Our treatment must be "'wholistic" and comprehensive. There is no such thing as a purely functional disorder or purely organic disease. Patients have an organic substrate upon which is superimposed a "psychogenic overlay." Symptom production often depends on the relative importance of the two. . . . .

With psychosomatic medicine we are therefore being helped to a better perspective to reintegrate the patient, his feelings, personality and background into the practice of medicine.

I would like to stress the thesis that psychotherapy is the art of medicine at its highest ethical plane, and is the responsibility of the family doctor. He is the one who should do the best psychotherapy.

A sterotyped approach is bad psychotherapy. It is good psychotherapy to examine every patient completely. The thorough physical examination constitutes one of the best nonverbal psychotherapeutic maneuvers we, as family doctors, have available to us. This can be destroyed in part if the patient feels that it is being carried out mechanically without regard for his feelings or his peculiar idiosyncrasies. The patient must be made to feel that the physician is really interested in him as a person and not in the methodology or in any isolated organ. I feel that the physician should be ready to modify his office ritual according to the emotional as well as the physical needs of the patient. So many doctors do this intuitively because they are good listeners and good observers. Others spend an hour in a tedium of painstaking history-taking to fill out all the lines on a blank and another hour or two looking at every square inch of epidermis and into every body orifice and still miss the obvious clews that the family doctor can pick up in two minutes. To me, nothing is more stultifying than to approach the patient with a head-to-toe list of questions as I was taught to do in medical school and as we still employ for writing up our case material . . . . . Those of you who have been in practice for many years know perfectly well that if you just let the patient talk, that most of the time he will tell you what is wrong with him. Another point that I wish to make is that no doctor should feel so pompous as to be ashamed to ask the patient what he or she thinks is the matter.

We need more doctors who are properly oriented who can appreciate and feel the patient's emotional needs as well as attend to all of his physical complaints. Only the family doctor can serve this function well . . . . . .

Some of the "old timers" were psychotherapists of the first order, and yet I am sure that many of them would have laughed at the idea of being called one. I dare say that for every patient helped by formal psychoanalysis, countless thousands have been helped by just such psychotherapists. They were not scientific, but as we know, psychotherapy probably never will be a science. "Psychiatry" to many of these oldsters was just so much mumbo-jumbo, but they practiced the brand of psychotherapy which we envy and about which we marvel. The kind of psychotherapy sometimes practiced by many of these men established them not only as keen clinicians, but as warm, understanding, kindly and tolerant physicians. . . . . .

Even for a working diagnosis, to classify a patient's illness as being either functional or organic is implying a dangerous concept. All patients have aspects of both. In some, for example an anxiety reaction, the predominant background may be emotional or, in the case of a fracture, might be classified as organic. However, some patients present the clinical picture of anxiety reaction and are cured when a substernal goiter is removed, and some patients with fractures are found to be accident-prone individuals. Could you call this psychosomatic or somatopsychic? Which kind of specialist is best equipped to handle this type of problem? Here again the answer is apparent: only the family doctor who not only has to evaluate the relative importance of each factor in the equa-

tion of the illness, but also has to be the entrepreneur in obtaining for the patient the neurosurgical, orthopedic, and physiotherapeutic skills which are needed in treatment. . . . . .

The discreet family doctor can often by superficial psychotherapy, including somatic methods such as sub-shock insulin, achieve more for the patient and for the family than can the psychiatrist in the big city. What appears queer or schizoid to a psychiatrist in a large metropolitan area sometimes may represent modes of thinking peculiar to the patient's family and environmental group. I recall that one of my patients saw a psychiatrist in a large midwestern city, and he was overly impressed by many of her peculiarities. When her local psychiatrist who had known her intimately for fifteen years and knew everything about her family and her city as well, heard of this, he chuckled and made the comment, "That ain't schizophrenia, that's Charleston."

Patients have families — and their psychotherapy must be directed at the family constellation as well as the patient. The family doctor is peculiarly suited to administer such therapy. The family doctor had better leave alone analytic methods, suggestive hypnotherapy, electroshock therapy and many other psychiatric methods in much the same manner as he would not attempt to do a lobectomy or a craniotomy. It is his job, however, to learn which patients are likely to be benefited by them, much in the manner that he learns which patients should consider surgery for cancer of the lung. . . . . The family doctor helps evaluate which patients can be helped. It is not wise to recommend psychoanalysis for a patient unless it is certain that the patient will be able to spend the time and money involved. If this is not possible, it is better for the patient not to embark on such therapy at all. . . . . .

Let me summarize:

All doctors, with the possible exception of pathologists, practice psychotherapy. Some do it knowingly, some without knowledge. Some do it differently; some do it indifferently. Psychotherapy like most things, can be good, bad, or indifferent. Good psychotherapists cannot be made out of bad doctors, but many good doctors are poor psychotherapists. The family doctor possesses the natural equipment, training and station to do the bulk of psychotherapy. This he must recognize and adapt to the utmost of all of his natural intuitive skills. It is his responsibility to mature emotionally, to overcome the mass of inferiority feelings which physicians at large have toward the emotional ills of the population.

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Correction of entropion

In many older patients, the lower eyelids become spastic because of an overaction of the fibers of the orbicularis muscle which lies close to the lid margin. The eyelashes are almost constantly inverted and cause irritation and lacrimation because of the constant rubbing against the cornea. This condition, known as entropion, can be relieved temporarily by drawing the skin of the lower lid down to evert the lid. Permanent relief can be obtained by surgical correction under infiltration anesthesia. A section of the loose skin below the lower lid margin, sufficient to prevent further inversion, is excised together with a few fibers of orbicularis muscle. A so-called senile type of ectropion, or eversion of the lower lids, also may occur. The lower eyelid turns outward because of loss of muscle tone and when sagging is present for a long period, the result is redness and thickening of the tarsal surface from exposure. There also is almost constant lacrimation because the lacrimal punctum is not in contact with the eyeball. A chronic form of conjunctivitis may result. Ectropion can be corrected by a simple surgical procedure under local infiltration anesthesia. *I. S. Tassman, M.D. Significance of Ocular Changes Occurring After Middle-Age. Geriatrics. Nov.* 1956.

COOK COUNTY HOSPITAL CASE RECORDS



Carcinoma of the Ampulla of Vater

ELI T. SAMET, M.D.*, AND FRANCIS H. STRAUS, M.D., F.A.C.S.**, CHICAGO

AMPULLARY and periampullary carinoma may arise from the ampulla of Vater, the end of the duct of Wirsung, the end of the common bile duct, glandular tissue of the head of pancreas, or the intestinal mucosa covering the papilla of Vater.[1] Incidence, based on autopsy findings, varies between 0.09% and 0.2% of carcinomas.[2] Histologically, it usually is adenocarcinoma.

Primary pancreatic and ampullary lesions may be difficult to differentiate. Cattell and Warren point out certain distinct differential diagnostic factors.[2] Table 1

TABLE 1

DIFFERENTIAL DIAGNOSIS BETWEEN CARCINOMA OF THE AMPULLA AND CARCINOMA OF THE PANCREAS.[2]

	Ca of Ampulla	Ca of Pancreas
Age	55.6 years	57.9 years
Sex ratio, male to female	2.7:1.0	2.8:1.0
Duration of symptoms	5.2 months	3.8 months
Symptoms		
Jaundice	100%	98%
Painless jaundice	65%	50%
Intermittent jaundice	14%	0%
Pain	35%	85%
Diarrhea	18%	46%
Chills and fever	20%	0%
Gall bladder palpable	30%	44%
Courvoisier's law at operation	85%	87%
Duct of Wirsung dilated at surgery	21%	50%
Weight loss	96 (av 18#)	100 (av 22#)

From the above it is noted that many common misconceptions this disease are refuted. Pain is to be expected in carcinoma of the pancreas and usually precedes jaundice, but is frequently absent in ampullary lesions where jaundice usually occurs early because of obstruction

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of the common bile duct and may account for the more favorable prognosis in this lesion.[1] Occult blood in the stools suggests an ampullary lesion. Weight loss, anorexia, and weakness seem to be common factors of both. Shackelford states that jaundice is often progressive in carcinoma of the ampulla but it may be intermittent or fluctuate over a period of months. This is especially true if there are episodes of chills and fever, indicative of attacks of ascending cholangitis.[1] Although no hard and fast rules apply, a patient with progressive jaundice, weight loss, weakness, anorexia, palpable gall bladder, and occult blood in the stool should be suspected of carcinoma of the ampullary region.

In spite of all laboratory tests, carcinoma of the ampulla seldom is diagnosed absolutely before surgery.[1] There usually is hyperbilirubinemia and elevated alkaline phosphatase and cholesterol. Early liver function tests may be normal. The urine usually contains bile but no uribilinogen. In addition to clay color, stools may contain occult blood and show evidence of pancreatic insufficiency. Serum amylase and lipase may be elevated, though usually not markedly. There usually is alteration of pancreatic enzymes in the duodenal contents and desquamative cytological studies may demonstrate malignant cells.

Various roentgenologic signs have been described involving changes in the duodenum, common duct, stomach, and transverse colon. However, at present, X-ray studies seem to be most helpful in demonstrating the absence of pathology in other surrounding organs, indicating a necessity for surgical exploration.[2] In Miller and associates' series, only 29.4% of cases showed a deformity of the papillary area.[9]

Billroth successfully removed the pancreas as early as 1884.[1] Halsted, in 1898, removed a carcinoma of the ampulla of Vater.[2] However, the modern era in treatment of tumors of the head of the pancreas and ampulla of Vater, commenced after Whipple, in 1935, demonstrated the surgical practicability of pancreaticoduodenal resection.[3] This operation has undergone numerous changes in its development. It can be performed in one or two stages, the latter if the patient is a poor operative risk. It consists of block resection of the head of the pancreas, lower end of the common bile duct, and the duodenum. Gastrointestinal continuity is restored by end-to-end or end-to-side gastroenterostomy. Biliary continuity is restored by anastamosing the common duct or gall bladder to the stomach or jejunum. Shackelford feels that restoration of pancreatic continuity is elective,[1] while Cattel states there are fewer postoperative complications when the duct of Wirsung is anastamosed to the mucosa of the intestine.[2]

In 102 pancreatico-duodenal resections listed by Cattel and Warren, some postoperative complication occurred in 55.[2] Pancreatic fistula was most common. A mucosa to mucosa (duct of Wirsung) pancreaticojejunostomy decreases the incidence of this complication.[2] Most fistulae will close spontaneously if constant suction through a Chaffin tube, sump drain, or some similar device is utilized. Some suggest the use of Banthine,® low fat diet, and other medical measures to decrease pancreatic secretions while, at the same time, protecting the skin around the tract from the digestive ferments.

Hemorrhage may occur early or late in the postoperative period and is best treated with fresh blood transfusions and parenteral administration of Vitamin K.[2] Other postoperative complications reported are biliary fistula, diabetes mellitus, obstruction of the gastrojejunal stoma, hepatitis, hepatic abscess, thrombophlebitis, and cerebral and coronary thrombosis. Of the 102 pancreatiocoduodenal resections performed by Cattell and Warren, there was a mortality rate of 17.3% for carcinoma of the pancreas and 6.6% for ampullary lesions.[2]

At least six patients with carcinoma of the pancreas and 13 with carcinoma of the ampulla of Vater have been reported by various authors to have survived pancreaticoduodenal resections for more than five years.[1] The original optimism passed on to considerable disillusionment when the five year statisites began to accumulate.[2,4,5] It is now felt that the standard pancreaticoduodenal resection has little to offer in carcinoma of the head of the pancreas. These discouraging results have led to more radical extensions of this procedure such as total pancreatectomy by Cattell[4], resection of the portal vein by Child[7], and removal of the portal vein with portocaval shunt by McDermott.[8] These procedures are still too new to be evaluated clinically. However, pa-

tients with carcinoma of the ampulla of Vater, even if not cured, receive effective palliation from a pancreaticoduodenal resection[6], and thus, the procedure is justified. There are four main contraindications[2]: (1) distant metastases; (2) local spread beyond limit of resection; (3) involvement of superior mesenteric vessels; (4) involvement of the portal vein.

Local excision of these tumors is not fruitful. In one series of 13 patients treated by this method, six died before leaving the hospital and of the seven remaining, the longest lived 44 months with evidence of recurrence.[6] Glenn also described a case where, after local excision of an ampullary tumor (less than one cm. in diameter) was performed, both gross impression and frozen tissue sections were benign, but permanent tissue sections revealed malignancy. Four months later the patient was reoperated and local recurrence with invasion of the pancreas, duodenum, and surrounding nodes was found.[6]

The preferred palliative procedure for inoperable cases is choleeystojejunostomy or cholodochojejunostomy. Sympathetic block with 95% alcohol has been used by some for relief of pain.[1,2] The main objective of these procedures is relief of pain and removal of the obstruction to bile drainage. Life expectaney usually is measured in months.[10]

CASE REPORT

C. K., a 71 year old white news stand operator was admitted to a medieal ward of the Cook County Hospital on May 4, 1956 with the primary complaints of jaundice (three months), abdominal pain (one month), dizziness (10 months), and a 30 pound weight loss (three months). He noticed his "eyes and skin becoming progressively more yellow," about three months prior to admission. There were no previous blood transfusions but he had received "injections" in 1953. No itching accompanied his jaundice. When icterus started he began having "eream colored stools and dark urine." One month before admission he developed a boring pain in his epigastrium unrelated to food intake or to any special time of day or event. Some relief of pain came when he passed gas rectally or took "tums and soda." He had surgery in 1905 and 1931 for "stomach ulcers" and was hospitalized in 1953 for "stomach pains and pains in his back." There was no history of hematemesis but stools were blaek on several occasions prior to their becoming cream colored. Three weeks before admission he passed a liquid stool which was "all blood" and on three subsequent occasions his stools were cream colored but mixed with "bright red blood."

Positive physical findings on admission showed a poorly nourished and poorly developed patient. His blood pressure was 170/80, pulse 68, respirations 20/minute, and temperature 98° orally. The skin was deeply jaundiced. The left tympanic membrane was perforated. An upper midline vertical scar was present. The liver border was two fingers below the right costal margin and the edge was sharp. The gall bladder was palpable. The stool color was yellow and four plus to benzedine test.

A gastrie analysis revealed no free acid. The following laboratory data were secured: Hb. 64% RBC 3.31 million; WBC 7,000; NPN 30 mg.%; total protein 6.1 grams %; icteric index 143 units; alkaline phosphatase 33.7 units; acid phosphatase 0.1 units; total cholesterol 127 mg. %; cephalin flocculation, two plus; thymol turbidity 5.4 units; gamma globulin 2.08; specific gravity of urine 1.013. The urine contained four plus bile and no uribilinogen. It was negative for acetone, blood, albumin, cells, bacteria, sugar, and casts. A barium meal, May 11, 1956, (Figure 1) reported a deformed duodenal bulb and an enlarged duodenal sweep compatible with an expending lesion of the head of the pancreas.

The patient was placed on Vitamins B,C,K and a high carbohydrate, high protein, low fat diet. He also received sulfasuxidine grams four q.i.d. and whole blood transfusions.

When his prothrombin time was elevated to 88% and hemoglobin level reached 80%, the patient was explored abdominally, under general anesthesia, through a long right paramedian incision (June 15, 1956). The liver was enlarged to two fingers below the costal margin and had a sharp edge. It showed evidence of extreme biliary cirrhosis. The gall bladder was dilated. An anterior gastrojejunostomy, about five inches from the ligament of Treitz, was seen and the stoma easily admitted two fingers. The duct of Wirsung could be palpated and was markedly dilated. The common duct was enlarged to one-one half inches in diameter.

The duodenum was mobilized by the Kocher



Figure 1. Preoperative barium meal.

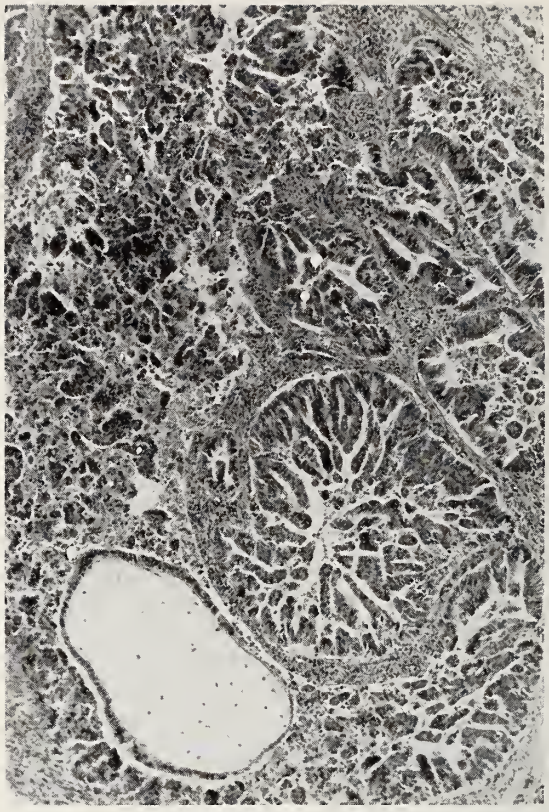


Figure 2. Photomicrograph papillary adenocarcinoma of ampulla of Vater.

maneuver and a mass palpated in the region of the ampulla of Vater. The duodenum was then opened longitudinally and a tumor visualized in the ampulla. This was biopsied and the frozen section reported as adenocarcinoma (Figure 2). The duodenum was then closed with a running suture of black silk. The third portion of the duodenum was mobilized, clamps applied, the duodenum severed and the distal end was closed with two layers of interrupted silk sutures. The gastrohepatic omentum was then incised and the right gastric and gastroduodenal arteries were isolated and doubly ligated. The common duct was then mobilized around its entire circumference and isolated by placing a tape around it for traction upward. A finger was easily slid along the upper surface of the portal vein beneath the head of the pancreas, emerging below the body of the pancreas just to the left of the superior mesenteric vein. No nodes were present in this area. The common duct was divided between clamps just above the entrance of the cystic duct. This necessitated removal of the gall bladder. The stomach was transected just above the pylorus and the pancreas was served at the uncinate process and the specimen removed in one piece (Figure 3).

The reconstructive phase followed. The distal end of the stomach was closed with two layers of intestinal catgut continuous, and one layer of interrupted silk sutures. The gastroenterostomy was not disturbed since it was patent. A Roux-en-Y was performed approximately two feet from the enterostomy and an end to end pancreaticojejunostomy was made. The duct of Wirsung was cannulated with a #109 polyethylene tube which was kept in place with one catgut suture. Two layers of black silk attached



Figure 3. Operative Specimen. Note marked dilitation of common duct. Arrow indicates tumor.

the seromuscular layer to the pancreatic capsule. An end to side choledochojejunostomy, in two layers was made about six inches below the pancreatic anastamosis and a #190 polyethylene catheter was placed free thru the anastamosis site. A Chaffin tube was inserted into Morrison's pouch and brought out thru a stab in the right flank. The abdomen was closed with catgut and the fascia and skin with wire.

The patient tolerated the procedure well. His blood pressure never receded below 112/70 and his pulse varied between 78 and 80 per minute throughout. He received 2000 cc. of whole blood during the course of the operation.

Postoperatively the patient was continued on Levin suction. In addition he received vitamins B, C, and K. Blood, plasma, and intravenous fluids were given, as necessary. His temperature never varied from normal during his entire postoperative course. On June 20, 1956 he passed a small amount of gas rectally. He had hypoactive bowel sounds and was placed on small amounts of liquid orally, supplemented with intravenous feedings. On the seventh postoperative day approximately 100 cc. of light brown drainage from the Chaffin tube was seen. The Chaffin-Pratt suction was immediately applied and the skin protected with aluminum paste. The drainage was pancreatic in origin. X-rays showed no free air and a normal bowel pattern. His abdomen was soft with hypoactive bowel sounds. He continued to have both bile and uribilinogen in his urine (2+ to 3+ of both) and brown stools until July 9th, when stools became clay colored and no uribilinogen appeared in the urine. On this date his blood chemistry was: NPN 24 mg.%; total protein 6.9 grams %; Na 139 mEQ/liter; Cl 106 mEQ/liter; alkaline phosphatase 31.8 units; icteric index 221 units; cephalin flocculation 3+; thymol turbidity 10.4 units; gamma globulin 2.16. An obstruction of the choledochojejunostomy was considered but thought unlikely because of the large size of the duct observed at surgery. A prothrombin time of 20% of normal prohibited further surgery.

The patient continued to take only small amounts of nourishment orally and, in spite of vigorous supportive therapy, continued progressively downhill and expired.

The family consented only to a reopening of the operative incision and inspection only of the abdominal contents. The liver was markedly enlarged and showed evidence of severe biliary cirrhosis. Approximately 100 cc. of pancreatic juice was pooled in the right upper quadrant and a small breakdown of the pancreaticojejunal anastamosis was discovered. The polyethlene tube was still in the duct of Wirsung. The choledochojejunal anastamosis was intact and patent and the duct showed no content of bile. Presumably the postoperative disappearance of bile from the duct and the stool was due to progression of the biliary cirrhosis. The abdominal cavity contained approximately 300 cc. of lower small bowel contents and the polyethylene catheter which had been placed at the choledochojejunal anastamosis was found floating free in the peritoneal cavity. The point of perforation in the small bowel could not be located.

COMMENT

A unique feature of the reconstructive phase of the operation was that by leaving the gastrojejunostomy intact, the patient's stomach was converted into a Mann-Williamson preparation. The justification for not taking down the anastamosis was: (1) the patient had no free acid on gastric analysis, hence, chances for developing ulcer were minimal, and (2) the patient was 71 years old and it would have prolonged the procedure and increased the operative hazard considerably.

The perforation of the small bowel by a small polyethylene catheter was an added complication which was not antieipated. Even though this probably was a terminal event, the possibility of its occurrence must be kept in mind.

SUMMARY

The case of a 71 year old male with carcinoma of the ampulla of Vater is presented. The diagnosis, differential diagnosis, and treatment are discussed. The complications of pancreatic fistula, progressive biliary cirrhosis, and perforation of the small bowel by a polyethylene catheter were encountered.

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Sitosterol

The reduction in serum cholesterol and other lipids produced by sitosterol can best be explained on the basis of its interference with absorption of cholesterol from the digestive tract. The effect is not necessarily identical with that of dietary restriction of cholesterol, since sitosterol might be expected to reduce absorption of cholesterol present in the bile as well as that present in the diet. That sitosterol does interfere with the absorption of cholesterol from the gut has been confirmed by Hernandez, using C14 labeled cholesterol. Two mechanisms of this interference with absorption have been proposed. Davis has demonstrated that under suitable conditions, cholesterol and sitosterol will form a mixed crystal which is much less soluble than either of the sterols alone, and he has suggested that sitosterol may act by combining with cholesterol in the gastrointestinal tract to form such crystals, thus binding the cholesterol and preventing its absorption. An alternative suggestion is that sitosterol competes with cholesterol for esterification, a step in the transport mechanism by which cholesterol is absorbed. Any attempt to evaluate the clinical efficacy of sitosterol in the management of atherosclerosis is beset by many difficulties. There are no available criteria for accurate assessment of the degree of atherosclerosis in the living patient. It is only when atherosclerosis has progressed to the point where there is significant interference with blood flow that it is clinically manifest. Even these late complications of atherosclerosis are a poor index of the extent of the disease, since they are dependent also upon the location of the atheromata. Extensive atherosclerosis of the aorta may defy detection, while a single plaque strategically placed in a coronary artery may lead to myocardial infarction and death. Despite these discrepancies between the degree of atherosclerosis and the occurrence of myocardial infarction, it is this group of patients that would seem to offer the best opportunity to evaluate agents of possible value in the treatment of atherosclerosis. Our observations to date are insufficient to draw conclusions regarding the effect of sitosterol on atherosclerosis. Of the 11 patients with myocardial infarction who have been treated, one died of myocardial infarction (his third) after three months of sitosterol administration. The remaining 10 have been treated for periods up to 29 months (mean, 15.8 months). There have been no recurrent infarctions in this group, and no toxic manifestations attributable to sitosterol. *Maurice M. Best, M.D. and Charles H. Duncan, M.D. Modification of Abnormal Serum Lipid Patterns in Atherosclerosis by Administration of Sitosterol. Ann. Int. Med. Oct.* 1956.

EDITORIALS

Harvey's tercentenary

This is the 300th anniversary of William Harvey's death. This contemplative and curious researcher waited 12 years after discovering the circulation of the blood to put his views into print. Similarly, Darwin waited 20 years, Jenner 18, and Lister eight before announcing the results of their research projects.

Our modern investigators may have the same patience but are hounded to tell their story to health editors, science writers, and public relations experts. Premature publicity does not help the scientific world but is a feather in the cap of men and women who are paid to keep the public informed. It also helps to increase the prestige of the laboratory, thus making it easier to get additional funds for research. Announcements of this type from the research laboratory of a pharmaceutical firm usually send their stock skyrocketing.

Fifty years elapsed before those best qualified to judge the work of Harvey appreciated its significance. His concept was a radical deviation from the past and was thought to be of no practical importance. Where would modern cardiology be without this discovery?

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Mastoid surgery

There has been an uptrend in mastoid surgery during the past five years. It does not approach the pre-antibiotie era of the early 30s but is noticeable, considering the total lack of this type of surgery during the 40s.

Smith[1] believes there are several reasons for the apparent upswing, especially among patients in the 20 to 70 age group. Many of these individuals are a carry-over from the pre-antibiotic era. They had disease of the middle ear and mastoid that had been treated unsuccessfully with medicine and surgery. The novelty of the antibiotics has worn off and these patients are willing to undergo an improved type of mastoid surgery.

Other diseases, such as malignancy of the mastoid and middle ear, are being recognized. In addition, mastoid surgery for the correction of congential defects, like auditory atresia, is now possible. Labyrinthotomy for intractable Meniere's disease via an endaural mastoid approach brings tremendous relief to these unfortunate victims. Operations of this type were seldom done 20 years ago.

The return of mastoid surgery in the younger age group is attributed to the increasing number of antibiotic resistant organisms. Some of these youngsters represent neglected cases; others are of the "too little, too late" type. At any rate, our embryo otolaryngologists are finding more and more opportunities to witness mastoid surgery and are no longer getting their material from cadavers.

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In Memoriam

Charles H. Phifer, M. D.

1879 - 1957

American medicine lost a great worker in the passing of Dr. Charles H. Phifer, 77, on March 27, in the Illinois Research Hospital, Chicago.

Dr. Phifer, beside having served as President of the Illinois State Medical Society and Chicago Medical Society, was active in the affairs of the American Medical Association. He had been hospitalized for about six months.

He was born in Shumway, Illinois, June 25, 1879, and was graduated from the University of Illinois College of Physicians and Surgery in 1902. He became a member of the Illinois 50-Year Member Club in 1952.

Dr. Phifer early in his career interested himself in the organizational activities of medicine, and in medical education. He served the University of Illinois for 40 years and at the time of his death was professor of surgery (emeritus).

He participated in committee and other activities of the Chicago Medical Society and was its President in 1934-1935. He served in the same capacity in the Illinois State Medical Society in 1941-1942.

Dr. Phifer was an Illinois delegate to the A.M.A. House of Delegates for 15 years. He also served on the A.M.A. Council on Scientific Assembly for 12 years, and on other committees.

World War II broke out during his term as President of the Illinois State Medical Society. This created problems for Illinois medicine which required extreme administrative ability to meet. This state was called upon to supply a large percentage of the physician requirements of the Armed Forces. At the same time, the medical needs of the citizens back home had to be met.

With the establishment of the War Manpower Commission's Procurement and Assignment Service for Physicians, Dr. Phifer was chosen to be the District Chairman for Illinois, Wisconsin and Michigan. He served his country with distinction. In 1942, he also was appointed by Gov. Green as Chairman of the Advisory Committee to the Illinois Council of Defense.

He served as Chairman of the Advisory Committee to the Illinois Emergency Relief Commission and with the organization of the Advisory Committee to the Illinois Public Aid Commision he became its first Chairman. He realized the need for voluntary medical insurance, and worked zealously for such coverage. He served as Chairman of the Medical Advisory Committee on Insurance until other duties made it necessary for him to resign.

In 1944, he helped to organize the Clinical Conference of the Chicago Medical Society. He continued active in organized medicine until illness prevented him from doing so.

Dr. Phifer was a member of the American Medical Association, Illinois State Medical Society, Chicago Medical Society and Institute of Medicine of Chicago, also a fellow of the American College of Surgeons. He was attending surgeon at the Illinois Central Hospital, and consulting surgeon at the Illinois Masonic Hospital, Chicago, and Delnor Hospital, St. Charles.

He lived at the Del Prado Hotel, 5307 Hyde Park Boulevard, and had offices at 30 North Michigan Avenue. He was a Scottish Rite Mason, Knight Templar and Shriner.

Surviving are his widow, Mrs. Marion G.; two daughters, Sally Jane and Marianne; a sister, Florence P. Bond, and a brother, Dr. Frank M. Phifer. To these we extend our deepest sympathies.

Medicine owes a debt of gratitude to this faithful servant, who served long and unstintingly.

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Blue Shield pays millionth claim

The payment of the one millionth claim marks an important milestone in the brief 10-year history of the Blue Shield Plan of Illinois Medical Service. Mrs. Dale Fox, of Farmersville, Illinois, was the millionth person to receive Blue Shield benefits and was presented with a plaque in honor of the occasion.

The Blue Shield Plan of Illinois Medical Service was founded by physicians in 1947, to help people pay their doctor bills. Since that time, this Blue Shield Plan has provided benefits totalling over $44,000,000.00. Payments to physicians now amount to over one million dollars a month.

In 1956 alone, this Blue Shield Plan paid $11,915,044.00 towards doctor bills for members. Both membership and benefits paid have more than doubled in the past five years.

Mrs. Fox is one of more than 1½ million Illinois residents who are protected against the high costs of sickness and accidents as members of Blue Shield. Their Blue Shield membership helps them pay their doctor bills for medical, surgical and obstetrical care by giving allowances toward the doctor's charges for his professional services.

Three years ago, Mrs. Fox became a member of Blue Shield and Blue Cross, the companion hospital care plan, with her husband Dale, and their children. They joined through the County Health Improvement Association in Montgomery County . . . which sponsors annual enrollments in these health care plans as one of its major community service projects. Thus farmers and those living in small towns . . . who are under 65 years of age and cannot otherwise enroll through groups where they work . . . are able to join the Plans through the HIA. A total of over 100,000 people now belong to this Blue Shield Plan through Health Improvement Associations in 79 counties in Illinois.

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They had problems sixty years ago

Perusal of Volume II of "History of Medical Practice in Illinois" shows that the present 'hassel' with the osteopaths is not something completely new. The osteopaths apparently introduced their first bill in 1897, and at the annual meeting in East St. Louis Dr. J. W. Pettit stated: "While our bill has been treated with contumely and contempt, a bill has passed the Senate unanimously and will almost certainly pass the House, exempting so-called Osteopaths from the provisions of our present Medical Practice Act. The practical effect of this bill, if it becomes law, will be to annul the present Medical Practice Act in so far as it has any effect in preventing quackery, leaving the profession and the public without any legal regulation of protection. I will say that this bill was introduced by Senator Granger who is a nice, pleasant old gentleman. I had a long conversation with him a few weeks ago, and found that he was urging the passage of this bill, and that he is really the man who is behind it in the Senate, not because he cares anything for so-called Osteopaths, but because he is a Christian Scientist, and the passage of the Osteopath Bill will open up the way for something else, and it is simply an outside skirmish line that has been thrown out to break down the Medical Practice Act. If this bill is passed, something else will follow."

The delegates became quite incensed over this and adopted a resolution protesting against any discrimination being shown any school of practice. There was a good deal of speech making about how medicine should be regulated in the legislature and it was felt by some that doctors who could afford it should go into politics themselves. In Iowa there were 12 physicians in the Senate, and the Osteopathy Bill was promptly defeated. In Illinois it passed both houses and was vetoed by the governor.

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Coronaries by the million

We have estimated that 1,000,000 attacks of coronary thrombosis occur annually in the United States. It is probable, therefore, that at least 1,500,000 to 2,000,000 attacks of "acute coronary insufficiency" occur each year. This figure probably is not too high, since coronary insufficiency usually is not fatal, since it may be too mild to be detected clinically, and since it is unlikely that many cases of insufficiency are diagnosed as coronary thrombosis on the basis of T wave changes alone in the electrocardiogram. Most incorrectly diagnosed cases undoubtedly are instances of coronary insufficiency. *Arthur A. Master M.D. et al. Acute Coronary Insufficiency: Its Differential Diagnosis and Treatment. Ann. Int. Med. Oct.* 1956

CORRESPONDENCE

Annual meeting Illinois Society of Anesthesiologists

Sunday May 19, 1957
Hotel Sherman, Chicago

9:00 a.m. Registration - The Old Chicago Room — No. 101

10:00 a.m. to 12:30 p.m. — *Scientific Program*

"Office Anesthesia" — *Herman J. Nebel, M.D.,* East St. Louis, Ill.

Symposium on Hypnosis:

"It is a Wise Hypnotist Who Knows Who is Hypnotizing Whom" — *Jules H. Masserman, M.D.,* Professor of Neurology and Psychiatry, Northwestern University Medical School, Chicago, Illinois

"Hypnosis From the Standpoint of the Anesthesiologist" — *Vincent J. Vaughn, M.D.,* Ottumwa, Iowa

Discussion to be opened by *Bernard K. Galston, M.D.,* Chicago

"Anesthetic Deaths" — *Valentino D. B. Mazzia, M.D.,* Asst. Attending Anesthesiologist New York Hospital, Instructor in Surgery (Anesth.) Cornell University Medical School, New York City.

12:45 to 1:45 p.m. — Round Table Luncheon— Gold Room No. 114.

2:00 p.m. *Scientific Program* — Old Chicago Room

"The Present Status of Conduction Anesthesia in Surgery, Obstetrics and Therapeutics", *Robert A. Hingson, M.D.,* Professor of Anesthesia, Western Reserve University School of Medicine, Cleveland, Ohio.

Business Meeting and Election of Officers to follow Scientific Program.

Bernard Stodsky, M.D., President
Ernest F. Kreutzer, M.D., Secretary

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Annual clinical and scientific meeting of the Illinois Surgical Society

Monday, May 20, 1957

Surgical Clinics — 8:00 a.m. at the Cook County Hospital, Harrison and Wood Streets, Chicago, Illinois

"Surgery of the Thyroid" ..... Leon J. Aries, M.D.

Discussion: — Leo Zimmerman, M.D., Howard P. Sloan, M.D., Everett P. Coleman, M.D.

"Surgery of the Biliary Tract and Pancreas" .. Panel Symposium

Moderator: — Raymond W. McNealy, M.D.

Collaborators: — Charles B. Puestow, M.D., Karl A. Meyer, M.D., Manuel E. Lichtenstein, M.D., Charles W. Christie, M.D.

"Axillary Dissection for Carcinoma of the Breast" ..... Louis P. River, M.D.

Discussion: — Clifford L. Carter, M.D., Willis I. Lewis, M.D.

"Care of Fractures" ..... Panel Symposium

George L. Apfelbach, M.D., Edward L. Compere, M.D., Robert T. McElvenny, M.D. David A. Bennett, M.D.

"Repair of Tendon and Nerve Lacerations" .... John L. Bell. M.D.,
Discussion: — Herbert H. Eighmy, Captain MC., U.S. Navy, Chester C. Guy, M.D.
"Fractures, Orthopedics, Trauma" ..... James J. Callahan, M.D.
"Surgery for Diseases of the Thoracic Cavity" .. George W. Holmes, M.D.
Discussion: — Ward H. Eastman, M.D., Robert A. DeBord, M.D.
"Surgery for Gynecologic Diseases" ..... Herbert E. Schmitz, M.D.
Discussion: — August F. Daro, M.D., Thomas B. Carney, M.D., Charles P. Blair, M.D.
"Gastrectomy" ..... Peter A. Rosi, M.D.
Discussion: — William Johnson, M.D., Nicholas J. Capos, M.D.
"Surgery of the Colon" ..... R. Kennedy Gilchrist, M. D.
Discussion: — James E. Graham, M.D., Raymond J. Kennedy, M.D.
"Surgery for Pyloric Stenosis" ..... Harry A. Oberhelman, M.D.
Discussion: — William L. Hall. M.D., George E. Kirby, M.D.
"Arterial Transplantation" ..... Egbert H. Fell, M.D., Milton Weinberg, M.D.
Discussion: - Morris T. Friedell, M.D., James W. West, M.D.
"Vagotomy and Gastroenterostomy" ..... Arkell M. Vaughn, M.D.
Discussion: — Kenneth H. Schnepp, M.D., Charles Allison, M.D.
"Neurosurgery" ..... Milton Tinsley, M.D.
"Colon Surgery" .. John B. O'Donoghue, M.D.
Discussion: — Mark Greer, M.D., Edwin A. Crowell, M.D.

Scientific meeting
Monday Evening, May 20, 1957 ....7:30 P.M.
University Club
Michigan Avenue and Monroe Street,
Chicago, Illinois

"Gastric and Peptic Ulcer Surgery" ..... George A. Hallenbeck, M.D.—Mayo Clinic.
Discussion: - Lester R. Dragstedt, M.D., Karl A. Meyer, M.D., Walter Palmer, M.D., Tilden C. Everson, M.D.

Medical Profession Invited To All Sessions
Plan Now To Attend.

Panel on tranquilizing drugs

Monday, May 20, 1957, 3:00 - 5:00 p.m.
Bal Tabarin Room, Hotel Sherman, Chicago

"Tranquilizing drugs" are presently being used with the same enthusiasm as the antibiotics, and new ones are appearing with comparable frequency. Since the trade or chemical names of these drugs offer little information concerning the actions, indications, and contraindications of these compounds, the discussion will include an objective evaluation of the pharmacology, toxicity, modes of action, behavioral effects, testing problems, clinical indications and hazards, as well as the social implications of the use of the most common tranquilizers in psychiatric, psychosomatic, and physical illnesses. The panel will include Dr. Francis J. Gerty, head of the Department of Psychiatry, University of Illinois College of Medicine; Dr. Roy R. Grinker, Director of the Institute for Psychosomatic and Psychiatric Research and Training at Michael Reese Hospital; Dr. Frederic A. Gibbs, Professor of Neurology, University of Illinois College of Medicine, and Director of the Electro-encephalographic Department, St. Luke's Hospital; Dr. Ralph W. Gerard, Professor of Neurophysiology (Psychiatry), University of Michigan Medical School; Dr. James G. Miller, Professor of Psychiatry, and Chief of the Mental Health Research Institute, University of Michigan Medical School; and Dr. Donald G. Marquis, Chairman of the Department of Psychology, University of Michigan. Dr. Gerald is also chairman of the National Advisory Committee to the Psychopharmacology Service Center, United States Public Health Service. Following the formal presentation there will be a question-and-answer period. Cocktails will be served during a later informal session. The afternoon program is sponsored by the Department of Psychiatry of the University of Illinois College of Medicine as part of an educational program for physicians initiated by the Wallace Laboratories.

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United States Committee of W.M.A. to meet in New York

The United States Committee of the World Medical Association will meet in the Waldorf Astoria Hotel, New York, June 4, during the annual meeting of the American Medical Association.

One of the objectives of the meeting will be to discuss with United States physicians ways and means of achieving the aims of the W.M.A., and to point out reasons why the Association should receive the support of American doctors.

The United States Committee during the A.M.A. meeting also will hold "open house" on the 12th floor of the Coliseum Towers, adjoining New York's Coliseum.

Membership in the United States Committee affords a fine opportunity to visit world famous centers of medical lore and historical interest as an official observer, according to Dr. Louis H. Bauer, secretary-treasurer. The next General Assembly scheduled is that in Istanbul, Turkey, September 29 to October 5.

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Woman's auxiliary's 29th annual meeting

The Twenty-ninth Annual Convention of the Woman's Auxiliary to the Illinois State Medical Society will be held May 21st, 22nd and 23rd at the Hotel Sherman, Chicago.

More than 2,000 physicians and their guests are expected to attend, according to the convention chairman, Mrs. S. M. Hubbard of Ridge Farm, Illinois.

While Tuesday morning, May 21st will include registration and a board meeting, the business session will begin at 1 P.M. with the Auxiliary President, Mrs. Robert E. Dunlevy, Pekin, presiding. Greetings from the Illinois State Medical Society will be extended by Dr. F. Garm Norbury, Jacksonville, Illinois, chairman of the advisory committee. A twilight memorial service will be conducted by Mrs. C. L. Bennett, Danville. In the evening, Mr. Paul Jones, director of public relations, National Safety Council, will be the guest speaker at the Public Relations Dinner. Following this, the auxiliary members will be the guests of the Illinois State Medical Society at the Beau Belle Ball.

The second general session on Wednesday, May 22nd will begin with a breakfast honoring Mrs. G. Henry Mundt, founder and first president of the Woman's Auxiliary to the Illinois State Medical Society and Mrs. James P. Simonds, Chicago, honorary publications chairman. Mrs. S. Glidden Baldwin will speak on "Job Opportunities Allied to Medicine" at this session. Highlight of the convention will be Dr. Nicholas Nyaradi, guest speaker at the luncheon. Dr. Nyaradi, former Minister of Finance in Hungary will speak on "The Fifth Freedom". Since coming to this country, he has lectured widely, receiving for his work a citation on behalf of the Crusade for Freedom. Dr. Nyaradi, now an American citizen, is chairman of the Economic Department of Bradley University of Peoria. The afternoon sessions will include the report of the county presidents and reference committee.

On Thursday, May 23rd, the convention will be concluded with the election of officers and the installation luncheon honoring the past presidents of the Woman's Auxiliary to the Illinois State Medical Society, Mrs. Robert E. Dunlevy and Mrs. Nicholas G. Chester, River Forest, president elect.

The chairmen assisting Mrs. Hubbard include: Information, Mrs. R. E. Westland, Skokie, Mrs. M. E. Uznanski, Chicago; Credentials and Registration, Mrs. Henry Christiansen, Chicago; Parliamentarian, Mrs. G. Hoffmann, Springfield; Revisions, Mrs. Lee Hamm, Lincoln; Continental Breakfast, Mrs. E. S. Hamilton, Kankakee; Luncheon, Mrs. W. R. Freeman, Mrs. L. L. Roseman, Champaign; Beau Belle Ball, Mrs. H. English, Danville, Mrs. D. D. Spicer, Danville; Program, Mrs. F. C. Endres, Peoria; Reference, Mrs. G. Carey, Joliet, Mrs. E. L. Wunsch, Aurora, Mrs. H. Kenneth Scatliff, Chicago; Courtesy and Resolutions, Mrs. W. W. Young, Chicago; Finance, Mrs. H. English, Danville; Nominating, Mrs. C. E. Sibilsky, Peoria; Past Presidents Luncheon, Mrs. W. B. Werner, Mrs. R. U. Grimmer, Pekin; Election Mrs. W. B. Wanninger, Chicago; Exhibits, Mrs. James M. McDonnough, Chicago; Favors, Mrs. M. G. Farinacci, Chicago; Hospitality, Mrs. J. S. Lundholm, Rockford, Mrs. N. D. Crawford, Pekin; Hospitality for Special Guests, Mrs. H. C. Hesseltine, Chicago; House, Mrs. G. L. Pastnack, Park Ridge; Pages, Mrs. L. J. Houda, River Forest; Press and Publicity, Mrs. J. W. Koenig, Blue Island; Reading, Mrs. E. M. Egan, Chicago; Tickets, Mrs. Wendell Roller, Monmouth; Timekeeper, Mrs. Wm. Somerville, Chicago.

Mrs. R. E. Dunlevy
President

Mrs. S. M. Hubbard
Convention Chairman

Mrs. J. W. Koenig
Press and Publicity

Conference on hypertension

The University of Michigan Regional Conference on Hypertension will take place in Ann Arbor, Michigan, June 7-8, 1957 in recognition of the 25th anniversary of the first production of experimental renal hypertension by Dr. Harry Goldblatt. Reports will be presented on the basic mechanisms of renal hypertension, including adrenal, neurogenic and renal aspects. Overseas participants will include, among others, Dr. Eduardo Braun-Menendez from Argentina; and Drs. Goldblatt, Helmer, Wakerlin, Skeggs, Kohlstaedt, Page, Kejdi and McCubbin from the Michigan regional area. Those desiring to attend are urged to write well in advance for information and reservations to Dr. John Sheldon, Director, Department of Postgraduate Medicine, University of Michigan Medical School, University Hospital, Ann Arbor, Michigan.

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The American Committee on Maternal Welfare

A comprehensive review of complete maternity care will be presented by The American Committee on Maternal Welfare at the Seventh American Congress on Maternal Care (formerly known as the *American Congress on Obstetrics and Gynecology*) to be held at the Palmer House, Chicago, July 8-12, 1957.

The five-day Congress — under the leadership of F. Bayard Carter, M.D., Professor and Head of the Department of Obstetrics and Gynecology at Duke University, Durham, North Carolina, and Samuel B. Kirkwood, M.D., Commissioner of Public Health for the Commonwealth of Massachusetts and Professor of Maternal Health at Harvard Medical School — will present topics dealing with the interprofessional approach to maternal and infant care. The Program Committee, composed of organizational representatives from obstetrics-gynecology, general practice, pediatrics, anesthesiology, nurse anesthesia, nursing, nutrition, public health, hospital administration, mental hygiene, and social service, has developed a program to afford maximum opportunity for audience participation.

Speakers and registrants at the panel discussions, luncheons, round tables, breakfast conferences and Laymen's Forum will examine and pursue the questions: "WHAT is Complete Maternity Care?" "WHO Provides It?" "HOW is Complete Maternity Care Provided?"

Many of the four thousand expected to attend are planning to combine a valuable educational experience with vacation.

Further information can be obtained by writing: The American Committee on Maternal Welfare, 116 South Michigan Avenue, Chicago 3, Illinois.

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The annual D. J. Davis Memorial lecture

The 1957 annual D. J. Davis Memorial lecture on medical history will be given at 1:00 p.m., Wednesday, May 15 in room 221 of the Medical-Dental-Pharmacy building, University of Illinois College of Medicine, 1853 West Polk Street, Chicago.

The speaker is Dr. Elmer Belt of Los Angeles, and his subject will be "Leonardo da Vinci's Medical Observations". Dr. Belt has had a very active interest in Leonardo da Vinci and is the author of a monograph on this subject.

All physicians and others interested in medical history are cordially invited to attend this interesting session.

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Courses for dental hygienists

The School of Dental and Oral Surgery in the Columbia University Faculty of Medicine today announced a revised curriculum in courses for dental hygienists. The new course of study provides a major area of specialization in dental hygiene, and a minor area in public health. Admission is based on sixty credits of college courses. The professional education is two academic years in length. All successful candidates are graduated with the Bachelor of Science Degree.

The new curriculum is designed to qualify graduates for a permanent dental hygiene teaching license in the public schools of New York State. It also prepares graduates for public health services as dental hygienists in local, state, and national dental health programs.

Concurrent with the new curriculum there has been a revision of admission requirements. A limited number of candidates who have completed the basic two year curriculum in dental hygiene will be admitted for the purpose of com-

pleting the study for the degree in dental hygiene.

Upon graduation, students may continue their education for the Master of Science Degree to prepare for teaching, supervision, and administration in schools for dental hygiene.

Clinics for crippled children listed for June

Twenty clinics for Illinois' physically handicapped children have been scheduled for June by the University of Illinois, Division of Services for Crippled Children. The Division will count 13 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing service. There will be 3 special clinics for children with cardiac conditions, 2 for children with rheumatic fever, and 3 for cerebral palsied children.

Clinics are held by the Division in co-operation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The June clinics are:

June 5 - Alton (Rheumatic Fever), Memorial Hospital

June 5 - Carmi, Carmi Township Hospital

June 5 - Hinsdale, Hinsdale Sanitarium

June 5 - Rock Island (Cerebral Palsy), Foss Home, 3808 - 8th Avenue

June 11 - East St. Louis, Christian Welfare Hospital

June 11 - Peoria, Children's Hospital (St. Francis)

June 13 - Springfield, St. John's Hospital

June 14 - Chicago Heights (Cardiac), St. James Hospital

June 19 - Chicago Heights General, St. James Hospital

June 19 - Elmhurst (Cardiac), Memorial Hospital of DuPage County

June 19 - Salem, Masonic Temple

June 20 - Rockford,-St. Anthony's Hospital

June 21 - Evanston, St. Francis Hospital

June 25 - Belleville, St. Elizabeth's Hospital

June 25 - Effingham (Rheumatic Fever), St. Anthony's Hospital

June 25 - Peoria, Children's Hospital (St. Francis)

June 26 - Elgin, Sherman Hospital

June 26 - Springfield (Cerebral Palsy), Memorial Hospital

June 27 - Bloomington a.m. (General) p.m. (Cerebral Palsy), St. Joseph's Hospital

June 28 - Chicago Heights (Cardiac), St. James Hospital

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Illinois Federation of the Blind speaker's bureau

The Illinois Federation of the Blind a not-for-profit corporation made up of twenty local organizations of blind people throughout the State of Illinois is happy to announce the establishment of a twelve member speakers bureau which will be available to the public as an educational service. The members of this bureau have been selected because they have demonstrated an ability to adjust to the handicap of blindness both from an economic as well as social standpoints. The membership includes such occupational fields as corporation executive, attorney, government administrator, secretary, business man, housewife, and a teacher.

One of the prime objectives of the speakers bureau is to bring to the public a realization of the importance of the prevention of blindness.

Speakers from this bureau will be available for speaking engagements before such groups as schools, churches, civic organizations and upon request. Their length of talk can be varied from 15 to 30 minutes in accordance with the program requirements of the group involved. Requests for a speaker should be made directly to the chairman of the publicity committtee, George Magers, 1612 N. 19th Street, Springfield, Illinois who will pass it on to the nearest member to the engagement. Requests should be submitted at least three weeks prior to the date involved. Requests will be acknowledged and a short biographical sketch of the speaker assigned will also be furnished at the time of the acknowledgement.

Robert O'Shaughnessy, President
130 W. Richmond Street
Peoria, Illinois

PROGRAM

One Hundred Seventeenth

ANNUAL MEETING
ILLINOIS STATE MEDICAL SOCIETY

Hotel Sherman **Chicago**

May 21, 22, 23, 24, 1957

PROGRAM SUMMARY

TUESDAY, MAY 21

9:00 a.m. House of Delegates, Louis XVI Room
Eye Ear Nose & Throat, Crystal Room
Anesthesiology, Assembly Room
Cardiovascular Disease, Gold Room No. 114
Obstetrics & Gynecology, Old Chicago Room No. 101

Noon:
Luncheon — Anesthesiology, Assembly Room

1:30 General Assembly, Ballroom
3:30 Radiology, Crystal Room
6:00 Public Relations Dinner, George Bernard Shaw Room
9:00 "Beau Belle Ball", Bal Tabarin

WEDNESDAY, MAY 22

9:00 Pediatrics, Louis XVI Room
Eye Ear Nose & Throat, Crystal Room
Pathology, Jade Room No. 103
Surgery, Old Chicago Room No. 101

9:30 Reference Committees:
Reports of Officers, Polo Room No. 102
Reports of Councilors, Holiday Room No. 105
Standing Committees, Orchid Room No. 106
Committee A, Gold Room No. 114
Committee B, Room No. 107
Committee C, Time Room No. 110
Committee D, Life Room No. 108
Miscellaneous Business, Ruby Room No. 113

Noon:
Luncheon — Pediatrics, Louis XVI Room
Academy of General Practice, Crystal Room
Fifty Year Club, Old Chicago Room No. 101
Pathology, Room No. 107

1:30 General Assembly, Ballroom
7:00 Annual Dinner, Ballroom

THURSDAY, MAY 23

8:00 Women Physicians Breakfast, Orchid Room No. 106
9:00 Second Meeting — House of Delegates, Louis XVI Room
Medicine, Crystal Room
Preventive Medicine and Public Health, Assembly Room
Illinois College of Chest Physicians, Gold Room No. 114
Dermatology, Old Chicago Room No. 101
Allergy, Room No. 107
10:30 Physicians' Association, Jade Room No. 103

Noon:
Luncheon — Illinois Chapter American College of Preventive Medicine — Assembly Room
College of Chest Physicians, Orchid Room No. 106
Dermatology, Old Chicago Room No. 101
Phi Chi Fraternity, Time Room No. 110
Physicians' Association, Life Room No. 108

1:30 General Assembly, The Ballroom
6:00 Loyola Alumni Dinner, Crystal Room
8:30 Third Meeting — House of Delegates, Louis XVI Room

FRIDAY, May 24

9:00 Joint Meeting with Illinois Bar Association, Illinois Medical Society, George Bernard Shaw Room

Noon:
Luncheon for speakers, Orchid Room No. 106

1:30 Joint Meeting with Illinois Bar Association, Illinois Medical Society, George Bernard Shaw Room
2:00 Illinois Association of Blood Banks, Old Chicago Room No. 101

Meetings of the House of Delegates

Louis XVI Room

(1) Tuesday, May 21

9:00 a.m. The first meeting of the House of Delegates will be called to order by the President, F. Lee Stone, for:

The Reports of Officers, Councilors, Committees, etc.

The introduction of resolutions, and for the transaction of any other business which may come before the House

THE COMMITTEE ON CREDENTIALS will meet at 8:00 a.m. Tuesday morning, May 21, in the entrance way to the Louis XVI Room. Delegates desiring to be certified as the official representatives of their county medical societies must present their credential cards to this committee.

(2) Thursday, May 23

9:00 a.m. The Second meeting of the House of Delegates will be called to order by the President to hear those reports of Reference Committees ready to be presented.

(3) Thursday, May 23

8:30 p.m. The third (and last) meeting of the House of Delegates will be called to order by the President to hear those reports of Reference Committees remaining to be presented;

For the election of officers, councilors, committee members, delegates and alternate delegates to the American Medical Association, and for the transaction of any other business to come before the House.

At the close of this last meeting, Lester S. Reavley will be installed as the new President of the Illinois State Medical Society, and will receive the official gavel from the retiring President, F. Lee Stone.

Programs for Tuesday, May 21, 1957

SECTION ON EYE, EAR, NOSE and THROAT

Tuesday Morning, May 21

Chairman ..... G. LeRoy Porter, Urbana
Secretary ..... Pierce Theobald, Chicago
Crystal Room

9:00 TUBERCULOUS ULCER OF THE CONJUNCTIVA — Case report.
Earl H. Merz, Chicago, Northwestern University Medical School, St. Luke's Hospital
John J. Walsh, Chicago, St. Luke's Hospital

9:10 LOSS OF ANTERIOR CHAMBER FOLLOWING CATARACT SURGERY
George Wyman, Peoria

9:30 DISCUSSION

9:40 CLINICALLY MALIGNANT LESIONS OF THE NOSE AND PARANASAL SINUSES
Arthur L. Ratko, Chicago, University of Illinois College of Medicine, St. Luke's Hospital

10:00 DISCUSSION

10:10 NON-PERFORATING INJURIES OF THE ANTERIOR SEGMENT
Clarence V. Ward, Peoria

10:30 DISCUSSION

10:40 PROBLEMS IN THE FUTURE OF MOBILIZATION SURGERY
Jerome A. Hilger, St. Paul, Minn., Clinical Professor of Otolaryngology, University of Minnesota Medical School, Minneapolis, Minn.

11:00 DISCUSSION

11:10 BUSINESS MEETING AND ELECTION OF 1958 SECTION OFFICERS

11:30 ADJOURNMENT TO VIEW EXHIBITS

SECTION ON OBSTETRICS AND GYNECOLOGY

Tuesday Morning, May 21

Chairman ..... Carl Greenstein, Champaign
Secretary ..... Vincent C. Freda, Chicago
Old Chicago Room No. 101

9:00 SYMPOSIUM: REPORT OF CASE STUDIES OF ILLINOIS MATERNAL WELFARE COMMITTEE OF ILLINOIS STATE MEDICAL SOCIETY
Frederick H. Falls, Oak Park, Presiding Professor of Obstetrics and Gynecology, Emeritus, University of Illinois College of Medicine

HEMORRHAGE: Willard C. Scrivner, East St. Louis

ECLAMPSIA: Worling R. Young, Geneseo
ANESTHESIA: Robert R. Hartman, Jacksonville
INFECTION: Ralph N. Redmond, Sterling
CONTROVERSIAL ASPECTS OF ABNORMAL UTERINE BLEEDING
Melvyn A. Bayly, Chicago
TREND IN MANAGEMENT OF CANCER OF CORPUS
Charles P. McCartney, Chicago, Assistant Professor of Obstetrics and Gynecology, University of Chicago College of Medicine
CLINICAL ASPECTS OF EXFOLIATIVE CYTOLOGY
Harold A. Kaminetzky, Chicago
INCIDENCE OF CANCER IN GERIATRIC WOMAN
Howard I. Ganser, Chicago
ELECTION OF 1958 SECTION OFFICERS
11:30 ADJOURNMENT TO VIEW EXHIBITS

SECTION ON ANESTHESIOLOGY

Tuesday Morning, May 21

Chairman ..... E. M. Dewhirst, Danville
Secretary ..... Herman J. Nebel, East St. Louis
Assembly Room

9:10 "ANESTHESIA PROBLEMS IN TRAUMA"
James A. Felts, Marion
9:40 "OBSTETRICAL ANALGESIA & ANESTHESIA"
Arthur T. Shima, Oak Park
10:10 RECESS TO VIEW EXHIBITS
10:40 "NITROUS OXIDE & L-DROMORAN"
Edward O. Kraft, St. Louis
11:10 "PRESENT STATUS OF CONDUCTION ANESTHESIA IN SURGERY, OBSTETRICS & THERAPEUTICS"
Robert A. Hingson, Cleveland, Ohio, Professor of Anesthesia, Western Reserve University
11:40 BUSINESS MEETING — ELECTION OF 1958 SECTION OFFICERS
12:00 SECTION LUNCHEON

SECTION ON CARDIOVASCULAR DISEASE

Tuesday Morning, May 21

Chairman ..... Emmet F. Pearson, Springfield
Secretary ..... George C. Sutton, Evanston
Gold Room No. 114

9:00 "SELECTION OF PATIENTS FOR MITRAL COMMISSUROTOMY"
Wright Adams, Chicago, Professor of Medicine, University of Chicago School of Medicine
9:20 "HAZARDS IN USE OF ANTIHYPERTENSIVE DRUGS"
Chauncey Maher, Jr., Springfield
9:40 "CONVENTIONAL RADIOLOGY IN CARDIOLOGY"
Ralph G. Willy, Evanston, Professor of Radiology, Northwestern University Medical School
10:00 RECESS TO VIEW EXHIBITS
10:40 "LONG-TERM ANTI-COAGULANT THERAPY IN THE MANAGEMENT OF CORONARY DISEASE"
Edward Cannaday, East St. Louis
"IDIOPATHIC CARDIOMEGALY IN ADULTS"
Robert L. Levy, New York, Professor Emeritus, Columbia University College of Physicians and Surgeons
BUSINESS MEETING AND ELECTION OF 1958 SECTION OFFICERS

SECTION ON RADIOLOGY

Tuesday Afternoon, May 21

3:30 p.m.

The guest moderator of the film reading session of the Section on Radiology will be Benjamin Felson, Professor of Radiology, University of Cincinnati College of Medicine, and Director of the Department of Radiology at Cincinnati General Hospital.

Following the scientific portion of the program, a business meeting and the election of Section Officers for 1958 will be held.

The Ballroom
Tuesday Afternoon, May 21

General Assembly

Presiding ..... Emmet F. Pearson, Springfield
Assisting ..... Hildegarde A. Schorsch, Chicago

1:30 Opening of the General Assembly
F. Lee Stone, Chicago, President, Illinois State Medical Society
1:40 NEWER CONTRAST METHODS IN DIAGNOSTIC ROENTGENOLOGY
Benjamin Felson, Cincinnati, Ohio, Professor of Radiology, University of Cincinnati College of Medicine, and Director of Department of Radiology, Cincinnati General Hospital
2:00 SOME CONTROVERSIAL ASPECTS OF MANAGEMENT IN CARDIAC INFARCTION
Robert L. Levy, New York, Professor

Emeritus of Medicine, Columbia University College of Physicians and Surgeons

2:20 NUTRITION AS A FACTOR IN COMMON DISEASE STATES
Robert E. Olson, Pittsburgh, Pennsylvania, Professor and Head of Department of Biochemistry and Nutrition, Graduate School of Public Health, Lecturer in Medicine, School of Medicine, University of Pittsburgh

2:40 RECESS TO VIEW EXHIBITS

Presiding ..... E. M. Dewhirst, Danville
Assisting ..... G. LeRoy Porter, Urbana

3:30 THE NATIONAL IMPLICATION OF THE 1956 POLIOMYELITIS OUTBREAK IN CHICAGO
Neal Nathanson, Atlanta, Georgia, Surgeon, United States Department of Public Health

3:50 OXYGEN IN THE DOCTOR'S SATCHEL
Robert A. Hingson, Cleveland, Ohio, Professor of Anesthesia, Western Reserve University

4:10 THE GENERAL PRACTICE APPROACH TO DEAFNESS
Jerome A. Hilger, St. Paul, Minnesota, Clinical Professor of Otolaryngology, University of Minnesota Medical School, Minneapolis

PUBLIC RELATIONS DINNER

GEORGE BERNARD SHAW ROOM
Tuesday Evening, May 21
6:00 p.m.

The Public Relations Dinner, sponsored by the Committee on Medical Service and Public Relations of the Illinois State Medical Society, will be held for the fifth consecutive year. Dr. Percy E. Hopkins, chairman of the Committee, will preside at the dinner.

Mr. Paul Jones, Director of Public Relations for the NATIONAL SAFETY COUNCIL, Chicago, will be the evening speaker. Medicine has become deeply interested in highway safety, and the public relations phase of this vital problem will provide an excellent program.

The chairmen of all county medical society committees on public relations will be the guests of the State Society. Any member of the Illinois State Medical Society interested in public relations and the many phases of this important work will be most welcome. The members of the Woman's Auxiliary have been especially invited this year in recognition of the importance of their work in the field of public relations. Tickets for the dinner will be sold for $3.50 each.

THE BEAU BELLE BALL

Bal Tabarin
Tuesday Evening, May 21
9:30 to 12:30

The "Beau Belle Ball" will be staged in the Bal Tabarin from 9:30 to 12:30. The Committee from the Woman's Auxiliary is headed by Mrs. Harlan English and Mrs. Donald D. Spicer of Danville. They will be assisted by the members of the Woman's Auxiliary to the Vermilion County Medical Society.

All physicians and their wives attending the 1957 annual meeting, and all technical exhibitors will be the guests of the Illinois State Medical Society at this affair.

Special entertainment has been planned — Benny Sharp and his Orchestra; Ravel of Hollywood; Carmen Lopez; etc. An evening of entertainment and dancing for your pleasure.

Programs for Wednesday, May 22, 1957

SECTION ON EYE, EAR, NOSE AND THROAT

Wednesday Morning, May 22

Chairman ..... G. LeRoy Porter, Urbana
Secretary ..... Pierce Theobald, Chicago
Crystal Room

9:00 BRONCHOLOGICAL ASPECTS OF PULMONARY FUNCTION TESTS
Albert H. Andrews, Jr., Chicago, Associate Clinical Professor of Bronchoesophagology, University of Illinois College of Medicine

9:20 DISCUSSION

9:30 ATOMIC ENERGY AND THE EYE
David V. L. Brown, Chicago, University of Illinois College of Medicine

9:40 DISCUSSION

10:00 SURGICAL PROBLEMS IN THE TREATMENT OF ADVANCED CARCINOMA OF THE HEAD AND NECK
William G. Hemenway, Chicago, University of Chicago

10:20 DISCUSSION

10:30 THERAPY OF CLOSED ANGLE GLAUCOMA
Robert W. Lennon, Joliet

10:50 DISCUSSION

11:00 OTOLARYNGOLOGIC ASPECTS OF THE CLEFT PALATE
Emanuel M. Skolnik

11:20 DISCUSSION

11:30 ADJOURNMENT TO VIEW EXHIBITS

SECTION ON PEDIATRICS

Wednesday Morning, May 22

Chairman ..... Noel G. Shaw, Evanston
Secretary ..... Raymond Eveloff, Springfield
Louis XVI Room

9:00 "HYPERTHYROIDISM IN CHILDREN"
John S. Hyde. Oak Park, Assistant Professor of Pediatrics. University of Illinois College of Medicine
I. Pat Bronstein, Chicago, Clinical Professor of Pediatrics University of Illinois College of Medicine
Mary Halpin, Greentree, Mass.

9:20 "JUVENILE DELINQUENCY"
James Gillespie, Urbana, Carle Clinic

9:40 "CAUSATIVE FACTORS OF BRAIN DAMAGE IN INFANTS AND CHILDREN"
Charles S. Textor, St. Francis Hospital, Evanston

10:00 "PRACTICAL ASPECTS OF FLUID BALANCE IN CHILDREN"
Michael J. Sweeney, Associate Medical Director, Mead Johnson, Evansville, Indiana

10:20 RECESS TO VIEW EXHIBITS

10:50 "LYMPHOMA"
Harold W. K. Dargeon, New York, Associate Professor, Clinical Pediatrics, Cornell University Medical College

11:20 SYMPOSIUM: "THE USE OF TRANQUILIZING DRUGS IN CHILDREN
Moderator: Meyer A. Perlstein, Chicago
—"IN NEUROMUSCULAR DISORDERS"
Meyer A. Perlstein, Chicago, Associate Professor of Pediatrics, Northwestern University Medical School
"IN PSYCHIATRIC STATES"
Harold E. Himwich, Galesburg, Galesburg State Research Hospital
"IN MENTALLY RETARDED"
Janet D. Rowley, Chicago, Research Fellow, Julian Levinson Foundation
"FURTHER POTENTIAL USES AND HAZARDS"
James Toman, Ph.D., Chicago, Assistant Professor, Department of Physiology and Pharmacology Chicago Medical School

12:15 BUSINESS SESSION — Election of 1958 Section Officers.

12:25 LUNCHEON
Illinois Chapter, American Academy of Pediatrics
Louis XVI Room

All physicians interested in problems and welfare of children are invited to attend. The luncheon will adjourn in time for the opening of the General Assembly Wednesday afternoon at 1:30 at which will be presented The President's Address, the Oration in Medicine and the Oration in Surgery.

SECTION ON SURGERY

Wednesday Morning, May 22

Chairman ..... David A. Bennett, Canton
Secretary ..... Richard H. Lawler, Chicago
Old Chicago Room No. 101

9:00 "THE ACUTE ABDOMEN (TRAUMA)"
William M. McMillan, Chicago, Assistant Professor of Surgery, Northwestern University Medical School; Consulting Surgeon, South Shore Hospital; Staff — Cook County and Wesley Memorial Hospitals

9:15 "INTUSSUSCEPTION IN THE ADULT"
Harold P. McGinnes, Bloomington

9:30 "PSEUDOCYST OF PANCREAS DUE TO TRAUMA"
Lorrin D. Whittaker, Peoria

9:45 "OLIGURIA AND ANURIA"
Vincent J. O'Conor, Chicago, Professor and Head of Department of Urology, Northwestern University Medical School; Chairman of Department of Urology, Wesley Memorial Hospital

10:00 RECESS TO VIEW EXHIBITS

10:30 PANEL SYMPOSIUM — "CARCINOMA OF THE SIGMOID COLON AND RECTUM"
Moderator: Karl A. Meyer, Chicago, Professor Emeritus Northwestern University Medical School; President, Chicago Medical Society; Chairman, Department of Surgery and Superintendent of Cook County Hospital; Chairman, Department of Surgery; Columbus Memorial Hospital
COLLABORATORS: R. Kennedy Gilchrist, Chicago, Professor of Surgery, University of Illinois College of Medicine; Attending Surgeon, Cook County, Presbyterian and Ravenswood Hospitals
Everett P. Coleman, Canton, President, Western Surgical Society; President, Illinois Surgical Society; Chairman of Staff, Graham Hospital, Canton
Vincent J. O'Conor, Chicago, Professor and Head of Department of Urology, Northwestern University Medical School; Chairman, Department of Urology of Wesley Memorial Hospital
Edwin M. Miller, Chicago, Professor of Surgery, University of Illinois College of Medicine; Attending Surgeon, Presbyterian Hospital

11:45 BUSINESS MEETING AND ELECTION OF 1958 SECTION OFFICERS.

SECTION ON PATHOLOGY

Wednesday Morning, May 22

Chairman ..... Dennis B. Dorsey, Danville
Secretary ..... Frederick Bauer, Chicago

Jade Room No. 103

9:00 PANEL DISCUSSION: The Clinician and Pathologist at the Bedside
MODERATOR: Dennis B. Dorsey, Danville

1. A CLINICIAN LOOKS AT NEW TESTS —A Practical Evaluation. Norman B. Roberg, Chicago
2. LABORATORY DATA — Significant or Meaningless. William S. Hoffman, Chicago
3. IS YOUR LABORATORY RELIABLE? Welland A. Hause, Decatur
4. THE UNSOLVED LABORATORY PROBLEMS OF A SMALL COMMUNITY HOSPITAL. S. B. Furby, Paxton

11:00 WHAT THE CLINICIAN EXPECTS FROM THE PATHOLOGIST — AND DOESN'T GET. Thomas Sellett, Sterling

WHAT THE CLINICIAN CAN GET FROM THE PATHOLOGIST — IF HE ASKS. George Milles, Chicago, Pathologist and Director of Laboratories, Augustana Hospital, and Professor of Pathology, University of Illinois College of Medicine.

QUESTION AND ANSWER PERIOD

12:00 LUNCHEON — and Business Meeting and Election of 1958 Section Officers. The luncheon will be served in Room No. 107.

Illinois Chapter

AMERICAN ACADEMY OF GENERAL PRACTICE

CRYSTAL ROOM

Wednesday Noon, May 22

11:45 a.m.

The Illinois Academy of General Practice has made arrangements to have a luncheon meeting again this year during the annual meeting of the Illinois State Medical Society.

All physicians are welcome to attend this luncheon. Members of the Illinois Academy are especially invited to attend.

Officers of the Illinois Academy of General Practice are:

O. A. Phipps ..... President
A. I. Doktorsky ..... President Elect
Robert Heerens ..... Vice President
Carl G. Sachtleben ..... Treasurer
H. Marchmont-Robinson ... Executive Secretary

FIFTY YEAR CLUB LUNCHEON

Wednesday Noon, May 22

Old Chicago Room No. 101

Andy Hall, Chairman of the Fifty Year Club since its formation in 1937, will preside again this year at the annual complimentary luncheon honoring the members of the FIFTY YEAR CLUB.

All physicians who have been in the practice of medicine for fifty years or more are invited as guests of the Illinois State Medical Society at one of the most popular social functions held during the annual meeting.

Tickets for the luncheon are complimentary and may be secured at the ticket desk during the first day of the meeting, or from Doctor Hall.

General Assembly

THE BALLROOM

Wednesday Afternoon, May 22

Presiding ..... David A. Bennett, Canton
Assisting ..... Robert M. Hoyne, Urbana

1:30 THE PRESIDENT'S ADDRESS: ILLINOIS MEDICINE—OFF TO BIG SECOND CENTURY
F. Lee Stone, Chicago, President, Illinois State Medical Society

2:00 THE ORATION IN MEDICINE: SOME THOUGHTS ON SPECIALIZATION IN MEDICINE
William B. Bean, Iowa City, Iowa, Professor of Medicine, University of Iowa Medical School

2:30 THE ORATION IN SURGERY: TERMINAL CARE
William F. Mengert, Chicago, Professor and Head of Department of Obstetrics & Gynecology, University of Illinois College of Medicine

3:00 RECESS TO VIEW EXHIBITS

Presiding ..... Noel G. Shaw, Evanston
Assisting ..... Carl Greenstein, Champaign

3:30 RETICULOENDOTHELIOSIS
Harold W. K. Dargeon, New York, Associate Professor of Clinical Pediatrics, Cornell University Medical College

3:50 THE ROLE OF SURGERY IN CANCER OF CERVIX
Willis E. Brown, Little Rock, Arkansas, Professor of Obstetrics and Gynecology, University of Arkansas School of Medicine

4:10 DIAGNOSIS AND TREATMENT OF SLIPPED FEMORAL CAPITAL EPIPHYSIS
John J. Fahey, Evanston, St. Francis Hospital

The Annual Dinner

The Ballroom
Wednesday Evening, May 22
7:00 o'clock

F. Garm Norbury, Immediate Past President .. .. Toastmaster
Invocation .....
The Reverend Lou Wallace Gade, D.D. Forest Park Presbyterian Church, Forest Park, Illinois
"They Went To College" .....
..... Bergen Evans, Ph.D. Department of English, Northwestern University, Evanston
Presentation of Health Progress Awards .....
..... F. Lee Stone, President
Introduction of Past Presidents and Guests ....
..... F. Garm Norbury, Toastmaster
Presentation of President's Certificate to F. Lee Stone .....
H. Close Hesseltine, Chairman of the Council
Dinner Music ..... Hamilton String Ensemble
Under the direction of Claude Johnson

Programs for Thursday, May 23, 1957

WOMEN PHYSICIANS' BREAKFAST

ORCHID ROOM No. 106
Thursday Morning, May 23
8:00 o'clock

On Thursday morning, May 23, the women physicians registered at the 1957 annual meeting will be the guests of the Illinois State Medical Society at a breakfast meeting.

This annual breakfast has been held for several years, and the women physicians have enjoyed a brief program before the scientific sessions for the day open at 9:00 a.m.

The committee in charge this year is composed of:

Augusta Webster, Chairman, Chicago
Elizabeth R. Fischer
Katharine Wright
Mary Louise Newman
Delores Lulinski
Ruth Church

Tickets may be secured at the registration desk until Wednesday afternoon, May 22.

SECTION ON MEDICINE

Thursday Morning, May 23
Chairman ..... Robert M. Hoyne, Urbana
Secretary .... William H. Wehrmacher, Chicago
Crystal Room

9:00-10:00
SYMPOSIUM: COMMON DIABETIC PROBLEMS AND THE ORAL HYPOGLYCEMIC AGENT
MODERATOR: Robert M. Kark, Chicago, Professor of Medicine, University of Illinois College of Medicine
Arthur R. Colwell, Jr., Evanston, Assistant Professor of Pediatrics, Northwestern University Medical School
Alvah L. Newcomb, Winnetka, Assistant Professor of Pediatrics, Northwestern University Medical School

10:00 RECESS TO VIEW EXHIBITS

10:30 CAPRICES OF INFECTIOUS MONONUCLEOSIS
Sheldon E. Krasnow, Oak Park, Clinical Assistant Professor of Medicine, University of Illinois College of Medicine

10:50 PHLEBOTHROMBOSIS AND PULMONARY INFARCTION
Charles F. Downing, Decatur

11:10 PSYCHIATRIC AID FOR THE OBESE
Katharine W. Wright, Chicago, W. Reed Brockback, Chicago
Discussion: M. David Allweiss, Chicago, Associate in Medicine, Northwestern University Medical School

11:30 BUSINESS MEETING — Election of 1958 Section Officers

SECTION ON ALLERGY

Thursday Morning, May 23

Chairman ..... Ellis Canterbury, Peoria
Secretary ..... Allan R. Feinberg, Chicago

Room No. 107

9:00 CAUSES OF DEATH IN BRONCHIAL ASTHMA
Robert Becker, Joliet

9:20 URTICARIAL PROBLEMS
John Sheldon, Ann Arbor, Michigan, Professor of Internal Medicine University of Michigan Medical School

9:40 PREVENTION OF HYPOSENSITIZATION REACTIONS
Leonard Harris, Peoria

10:10 RECESS TO VIEW EXHIBITS

10:30 PANEL DISCUSSION: FOOD ALLERGY
Leon Unger, Chicago
Helan C. Hayden, Chicago
Milton M. Mosko, Chicago
Abe Matheson, Chicago

11:30 BUSINESS MEETING and election of 1958 Section Officers

SECTION ON DERMATOLOGY

Thursday Morning, May 23

Chairman ..... Malcolm Spencer, Danville
Secretary ..... John M. McCuskey, Peoria

Old Chicago Room No. 101

9:00 SYMPOSIUM — THE MANAGEMENT OF COMMON SKIN DISEASES
COMMON CUTANEOUS MANIFESTATIONS OF VIRUS DISEASES
Malcolm Spencer, Danville, Chairman, Section on Dermatology

9:30 PANEL — THE MANAGEMENT OF WARTS
This panel will stress the treatment of all types of warts. Kodachromes of exemplary cases will be presented for discussion
MODERATOR: Julius E. Ginsburg, Chicago Associate Professor of Dermatology Northwestern University School of Medicine
Paul P. Boswell, Chicago
Myron H. Kulwin, Champaign
Oliver Rian, Peoria
Arthur C. Curtis, Ann Arbor, Michigan

10:30 RECESS TO VIEW EXHIBITS

11:00 PANEL — ECZEMA OF INFANCY AND CHILDHOOD
This panel will stress the treatment of different types of eczema in infancy and childhood. Kodachromes of exemplary cases will be presented for discussion
MODERATOR — Francis E. Senear, Chicago, Professor Emeritus, Department of Dermatology, University of Illinois School of Medicine
Frederick D. Malkinson, Chicago, Assistant Professor of Dermatology, University of Chicago School of Medicine
Harold H. Rodin, South Bend, Indiana, Associate, Department of Dermatology, Northwestern University School of Medicine
Louis Rubin, Rockford, Clinical Instructor in Dermatology, University of Illinois School of Medicine
Cornelius A. VanderLaan, Chicago, Clinical Instructor in Dermatology, University of Illinois School of Medicine
Arthur C. Curtis, Ann Arbor, Michigan, Professor and Chairman, Department of Dermatology, University of Michigan School of Medicine

12:00 LUNCHEON for members of the Section and their guests
BUSINESS MEETING and election of 1958 Section Officers
Adjournment in time to attend the General Assembly in the Ballroom at 1:30 p.m.

SECTION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH

Thursday Morning, May 23

Assembly Room

Chairman ..... Herbert Ratner, Oak Park
Secretary ..... Jackson P. Birge, Rock Island

9:00 A REVIEW OF ANTIDIABETIC COMPOUNDS
Carl A. Hedberg, Chicago

9:20 RADIATION OBVIATING NECESSITY FOR SURGERY IN THYROID DISEASE
Lindon Seed, Chicago

9:40 PREVENTIVE ASPECTS OF RHEUMATIC FEVER
Gene H. Stollerman, Chicago

10:10 DEMONSTRATION OF NORMAL AND PATHOLOGICAL HEARD SOUNDS
Jacques M. Smith, Chicago

10:30 THE FUTURE OF SYPHILIS CONTROL
Evan W. Thomas, New York, Professor of Clinical Medicine (Syph.) New York University College of Medicine, New York

11:15 BUSINESS SESSION and election of Section Officers for 1958

11:30 ADJOURNMENT TO VIEW EXHIBITS

LUNCHEON .... Illinois Chapter AMERICAN COLLEGE OF PREVENTIVE MEDICINE

Thursday Noon, May 23

Luncheon speaker — Theodore R. Van Dellen — Preventive Medicine Through Health Columns

Adjournment at 1:30 to attend General Assembly in the Ballroom.

Illinois Chapter

AMERICAN COLLEGE OF CHEST PHYSICIANS

Gold Room No. 114

Thursday Morning, May 23

18th Annual Meeting

9:00 OPENING OF THE MEETING

Presiding: William M. Lees, Chicago, President, Illinois Chapter

9:10 PANEL DISCUSSION — ESOPHAGEAL DISEASE

MODERATOR: Williams E. Adams, Chicago, Raymond Professor of Surgery, University of Chicago Medical School

Albert H. Andrews, Jr., Chicago, Associate Clinical Professor of Bronchoesophagology, University of Illinois College of Medicine

Franklin A. Kyser, Chicago, Assistant Professor of Medicine Northwestern, University Medical School

James W. C. Carpender, Chicago, Professor of Radiology, University of Chicago Medical School

Questions and discussions from the floor

11:00 THE PLACE OF HISTOPLASMOSIS IN CHEST MEDICINE

Henry C. Sweany, Mount Vernon, Missouri, Director of Research, Pathology and Allied Sciences, Missouri State Sanatorium

12:00 Noon LUNCHEON — Orchid Room No. 106

Business meeting and election of officers —Illinois Chapter, American College of Chest Physicians.

PHYSICIANS' ASSOCIATION OF THE Department of Public Welfare State of Illinois

Thursday Morning, May 23

Jade Room No. 103

Chairman: Werner Tuteur, Clinical Director, Elgin State Hospital, Elgin

10:30 THE MENTAL HOSPITAL PHYSICIAN

Werner Tuteur, Elgin

(1) SOME ERRORS IN CHANGES TO TREATMENT ATTITUDES

Kalman Gyarfas, Chicago, Superintendent, Chicago State Hospital

(2) GROUP TREATMENT OF THE CHRONIC SCHIZOPHRENIC, THE UNSELECTED GROUP IN MENTAL HOSPITALS

Jacob W. Klapman, Chicago, Chicago State Hospital

(3) ANNUAL PATIENT SURVEY

Leonard Horecker, Anna Clinical Director, Anna State Hospital

Martin S. Sloane, Anna Assistant Superintendent, Anna State Hospital

12:00 Luncheon in the Life Room No. 108

This luncheon will adjourn at approximately 1:15 in order that those in attendance may be present at the General Assembly in the Ballroom that afternoon.

PHI CHI FRATERNITY LUNCHEON

TIME ROOM No. 110

Thursday Noon, May 23

The Phi Chi Fraternity will have its annual luncheon on Thursday noon, May 23, in The Time Room No. 110 on the first floor of the Hotel Sherman.

Dr. Jacob E. Reisch of Springfield, Editor of the Phi Chi Bulletin, will be in charge of the plans.

All members of the fraternity are welcome to attend.

General Assembly

The Ballroom

Thursday Afternoon, May 23

Presiding ..... Ellis Canterbury, Peoria

Assisting .....Malcolm Spencer, Danville

1:30 SOME INTERESTING FACETS OF THE COLLAGENOUS DISEASE PROBLEM

Arthur E. Curtis, Ann Arbor, Michigan, Professor and Chairman, Department of Dermatology and Syphilology, University of Michigan Medical School

1:50 THE GENERAL PRACTITIONER AND SYPHILIS

Evan W. Thomas, New York, Professor of Clinical Medicine (Syph.), New York University College of Medicine, New York

2:10 THE PREVENTION OF ALLERGIC REACTIONS

John M. Sheldon, Ann Arbor, Michi-

gan, Professor of Internal Medicine, University of Michigan Medical School, Ann Arbor

2:30 RECESS TO VIEW EXHIBITS

Presiding ..... Dennis B. Dorsey, Danville

Assisting ..... Herbert Ratner, Oak Park

3:10 THE PATHOLOGIST AND YOUR PATIENT

George Milles, Chicago, Pathologist and Director of Laboratories, Augustana Hospital. Professor of Pathology, University of Illinois College of Medicine.

3:30 PERSONALITY PROBLEMS IN TRAFFIC SAFETY

Mr. James Stannard Baker, Chicago, Northwestern University Traffic Institute

3:50 NARCOTISM AND ALCOHOLISM

Eugene Carey, Chicago, Chicago Police Department

4:10 GLAUCOMA DETECTION IN GENERAL PRACTICE

Edward Gallardo, LaSalle

LOYOLA UNIVERSITY ALUMNI DINNER

CRYSTAL ROOM

Thursday Evening, May 23

6:00

The Medical Alumni of the Stritch School of Medicine, Loyola University, will meet for their annual dinner during the Illinois State Medical Society meeting on Thursday evening, May 23, in the Crystal Room of the Hotel Sherman.

Dr. Maurice M. Hoeltgen, Chicago, class of 1932, is serving as chairman for the dinner. Dinner will be served at 6:00 p.m. The price is $6.50 per person.

Reunions will be held with the following classes:

30 year class (1927) Anthony B. Traub, Chairman

25 year class (1932) Francis W. Hetrecd, Chairman

20 years class (1937) A. C. Wendt, Jr., Chairman

10 year class (1947) Matthew Bulfin, Chairman

Tickets will be on sale during the meeting at the registration desk on the mezzanine floor.

Programs for Friday, May 24, 1957

Joint Meeting

ILLINOIS STATE BAR ASSOCIATION

ILLINOIS STATE MEDICAL SOCIETY

GEORGE BERNARD SHAW ROOM

Friday, May 24

CHAIRMEN: Leo S. Karlin, Attorney at Law, Chicago

Leo P. A. Sweeney, M.D., Chicago

9:00 OPENING REMARKS:

Lester S. Reavley, President, Illinois State Medical Society, Sterling

James G. Thomas, President, Illinois State Bar Association, Champaign

9:10 THE DOCTOR AND THE COURTS

Irwin W. Roemer, Trial Attorney, Chicago

Interprofessional Relationship

Medical and Legal Concepts of Causation

Payments — for reports, court appearances, Subpoenas, Protection of fees.

9:30 MALPRACTICE

Charles M. Rush, Trial Attorney, Chicago

Impact of this type of Litigation as it affects doctors in their work.

9:50 PREPARATION OF MEDICAL AND LEGAL PHASES

Louis G. Davidson, Trial Attorney, Chicago

Before Trial and For Trial: Medical reports—Hospital Records—Office Records—Consultation—Question of Privileged Medical Communications.

Interprofessional Cooperation: Consultation before Trial and Conduct in Court Room.

10:10 MEDICAL DEMONSTRATIVE EVIDENCE

Leo S. Karlin, Trial Attorney, Chicago

Simplifying Medical Testimony: Medical drawings, Skeletons, Charts, Blackboards and other visual aids.

10:30 AS THE DOCTOR SEES THE COURT AND THE LAWYER

Carlo Scuderi, M.D., Orthopedic Surgeon, Chicago

Doctor-Lawyer Relationships: Cooperation—Conflicts

The Court: Preparation—the Summons —Awaiting call to the Stand. Conduct as a witness.

10:50 RECESS TO VIEW EXHIBITS

11:20 PANEL FOR QUESTIONS AND ANSWERS

MODERATOR: Leo P. A. Sweeney, M.D.

Irwin W. Roemer, Attorney

Charles M. Rush, Attorney

Louis G. Davidson, Attorney

Leo S. Karlin, Attorney
Carlo Scuderi, M.D., Surgeon

12:30 LUNCHEON

1:30 CHEMICAL TESTS FOR INTOXICATION: Scientific Background and Public Acceptance

Herman A. Heise, M.D., Milwaukee, Wisconsin

MOCK TRIAL DEMONSTRATION: Drunk Driving Case

Expert Medical Witness — William W. Bolton, M.D., Chicago Associate Director, Bureau of Health Education, American Medical Association

Police Technician — Captain Robert F. Forkenstein, Indiana State Police, Indianapolis, Indiana

Arresting Officer — Joseph Cavanaugh, Chicago Police Department, Chicago

Defendant — George B. Larson, Assistant Director, Bureau of Exhibits, American Medical Association, Chicago.

Prosecuting Attorney — Edwin J. Holman, Law Department, American Medical Association, Chicago

Defense Attorney — William J. McAuliffe, Jr., Law Department, American Medical Association, Chicago

Judge — C. Joseph Stetler, Director, Law Department, American Medical Association, Chicago

4:30 Adjournment.

The Illinois
ASSOCIATION OF BLOOD BANKS
CHICAGO ROOM No. 101
Friday Afternoon, May 24

2:00 p.m.

THE IMPORTANCE OF CONTROLS IN Rh TYPING, Blood Grouping and Cross Matching — A Review.

Florence Gerard — 10 minute presentation and 5 minute discussion

SECTION ON HEMOLYTIC DISEASE OF THE NEWBORN

Erythroblastosis due to ABO Incompatibility, Kurt Stern — 10 minute presentation, 5 minute discussion

Erythroblastosis due to anti-Duffy (Anti-fy^a), C. Schlutz, L. I. Dagovitz, M. Sacks, F. Leeming — 10 minute presentation, 5 minute discussion.

Erythroblastosis due to Anti-C^w. M. Sacks, C. Schlutz, L. I. Dagovitz, M. Vanecko — 10 minute presentation, 5 minute discussion

A Rare Instance of Erythroblastosis due to anti-Rho Sensitization in a Du Mother, L. I. Dagovitz, C. Schlutz, A. M. Wolf — 10 minute presentation, 5 minute discussion

THE PROPERDIN SYSTEM

Kenneth Robbins — 15 minute presentation, 10 minute discussion

PANEL DISCUSSION — The Value of the Clearing House Program in Illinois, Coye C. Mason, Paul VanPernis, Donald R. Russ, M. Appel — 20 minute discussion

Technical Exhibitors

Abbott Laboratories, Inc., North Chicago, Illinois, Booth 56

Audio-Digest Foundation, Glendale, California, Booth 66

Baby Development Clinic, Chicago, Illinois, Booth 25

Baker Laboratories, Inc., Cleveland, Ohio, Booth 8

Baxter Laboratories, Inc., Morton Grove, Illinois, Booth 51

Blue Cross-Blue Shield, Chicago, Illinois, Booths 20-21

Brooks Appliance Company, Chicago, Illinois, Booth 4

Chicago Pharmacal Company, Chicago, Illinois, Booth 57

Chicago Reference Book Co., Chicago, Illinois, Booth 67

Ciba Pharmaceutical Products, Inc., Summit, New Jersey, Booth 9

The Coca Cola Company, Atlanta, Georgia, Booth 17

Daniels Surgical & Medical Supplies, Chicago, Illinois, Booths 15-16

Dayless Manufacturing Company, Chicago, Illinois, Booth 13

Desitin Chemical Company, Providence, Rhode Island, Booth 38

Doho Chemical Corporation, New York, New York, Booth 29

Eaton Laboratories, Norwich, New Jersey, Booth 12

Eisele & Company, Nashville, Tennessee, Booth 27

Eli Lilly & Company, Indianapolis, Indiana, Booths 31-32

Encyclopedia Americana, Grand Rapids, Michigan, Booth 63

Encyclopaedia Britannica, Chicago, Illinois, Booth 69

E. Fougera & Company, New York, New York. Booth 26
Geigy Pharmaceuticals, Yonkers, New York, Booth 54
Great Books of the Western World, Chicago, Illinois, Booth 45
H. J. Heinz Company, Pittsburgh, Pennsylvania, Booth 3
Jackson-Mitchell Pharmaceuticals, Inc., Culver City, California, Booth 34
Lederle Laboratories, Inc., Pearl River, New York, Booth 6
The Liebel Flarsheim Company, Cincinnati, Ohio, Booth 10
J. B. Lippincott Company, Philadelphia, Pennsylvania, Booth 47
Loma Linda Food Company, Arlington, California, Booth 42
S. E. Massengill Company, Bristol, Tennessee, Booth 2
Mead Johnson & Company, Evansville, Indiana, Booth 5
Medco Products Company, Tulsa, Oklahoma, Booth 23
The Medical Protective Company, Fort Wayne, Indiana, Booth 64
Merck & Company, Inc., Rahway, New Jersey, Booths 40-41
Merck, Sharp & Dohme, Philadelphia, Pennsylvania, Booth 60
V. Mueller & Company, Chicago, Illinois, Booth 22
National Live Stock & Meat Board, Chicago, Illinois, Booth 50
A. R. Nechin Company, Chicago, Illinois, Booth 46
Nordmark Pharmaceutical Laboratories, Irvington, New Jersey, Booth 39
Northern Illinois Medical Service, Inc., Rockford, Illinois, Booth 37
Parke, Davis & Company, Detroit, Michigan, Booth 65
Parker, Aleshire & Company, Chicago, Illinois, Booth 19
Pfizer Laboratories, Brooklyn, New York, Booth 55
Professional Management, Bloomington, Illinois, Booth 24
Profexray, Inc., Maywood, Illinois, Booth 18
Purdue Frederick Company, New York, New York, Booth 68
Reed & Carnrick, Jersey City, New Jersey, Booth 43
R. J. Reynolds Tobacco Company, Winston-Salem, North Carolina, Booth 14
A. H. Robins Company, Inc., Richmond, Virginia, Booth 58
J. B. Roerig & Company, Chicago, Illinois, Booth 62
The Sanborn Company, Cambridge, Massachusetts, Booth 30
W. B. Saunders Company, Philadelphia, Pennsylvania, Booth 59
The Schering Corporation, Bloomfield, New Jersey, Booth 53
Julius Schmid, Inc., New York, New York, Booth 44
G. D. Searle & Co., Chicago, Illinois, Booth 52
7-Up Developers Association, Chicago, Illinois, Booth 1
Sherman Laboratories, Detroit, Michigan, Booth 28
Smith, Kline & French Laboratories, Philadelphia, Pennsylvania, Booth 7
E. R. Squibb & Sons, New York, New York, Booth 35
United States Tobacco Co., New York, New York Booth 36
The Upjohn Company, Kalamazoo, Michigan, Booth 61
Vitamin Products Co., Milwaukee, Wisconsin, Booth 49
Wallace Laboratories, New Brunswick, New Jersey, Booth 33
Winthrop Laboratories, New York, New York, Booth 11
The Zemmer Company, Pittsburgh, Pennsylvania, Booth 48

Exhibitors merit and will

appreciate your visit

Local Committees

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Chairman ..... Patrick H. McNulty, Chicago
Vice Chairman ..... Lorne Mason, Evanston

ADVISORY COMMITTEE

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Vice Chairman .. Maurice M. Hoeltgen, Chicago

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Arkell M. Vaughn	C. Paul White

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ANNUAL DINNER COMMITTEE

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Vice Chairman, John B. O'Donoghue, Jr., Chicago

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J. P. Nesselrod	John Ferrin
Norman Meyer	Charles Vil
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Seth Brown	Wayne Flora
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Martin Fahey	S. J. Sullivan
Tom Saletta	Frank Murphy
Louis Brody	George Blaugh

Charles Green

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Vice Chairman ..... John O. Firth, Monmouth

Otto L. Bettag	L. M. Hardy
Gustav Kaufman	Charles W. Stigman

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John A. Mirt

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Vice Chairman .. George E. Kirby, Spring Valley

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R. Hohf	Phillip Baker
L. Giomasi	John Brosnan
Haig Hyde	Peter Bartkus
John O'Malley	Jack W. Davis
E. M. Rice	Edward Clancy
P. Bedinger	Edward Brophy
J. Bailey	Steve Reed
E. Witt	J. E. Wheeler

WOMEN PHYSICIANS' BREAKFAST COMMITTEE

Chairman ..... Augusta Webster, Chicago

Elizabeth R. Fischer	Katharine W. Wright
Mary Louise Newman	Dolores P. Lulinski

Ruth Church

LIAISON COMMITTEE — AUXILIARY PARTY

Chairman ..... Frederic M. Nicholson, Chicago

William E. Adams	Warren C. Blimm
A. L. Burdick	J. R. Burnett
Ralph E. Dolkart	G. J. A. Dundon
John C. Dwyer	James E. Ellis
Casper M. Epstein	Vincent J. O'Connor
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Noel Shaw	L. S. Tichy
George C. Turner	Karl L. Vehe
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Scientific Exhibits

Coye C. Mason, Director and Chairman . Chicago
Arkell M. Vaughn ..... Chicago
William E. Adams ..... Chicago
Leo M. Zimmerman ..... Chicago
L. W. Peterson ..... Chicago
Harold L. Method ..... Chicago
Everett P. Coleman ..... Canton
J. C. Thomas Rogers ..... Urbana

BOOTH 1

"The Viral Etiology of Leukemia"
Steven O. Schwartz, Harold M. Schoolman, Paul B. Szanto, Wilma Spurrier, LeRoy Yates

The Hektoen Institute for Medical Research of the Cook County Hospital, Chicago, Illinois.

The exhibit describes, in terms of the author's work, the evidence for the viral etiology of leukemia and the possible relationship of the experimental evidence in animals as it may be applicable to humans.

BOOTH 2

"The Undescended Testes Problem"
Norris J. Heckel, James H. McDonald, James A. Calams

University of Illinois, College of Medicine, Presbyterian Hospital and Ravenswood Hospital, Chicago, Illinois.

The exhibit emphasizes the endocrine and surgical treatment of the undescended testes. Photomicrographs of scrotal and undescended testes at various ages emphasize the necessity of treatment at an early age. Depiction of location and pathological anatomy of testes that do not normally descend is illustrated by drawings centered about a large wax model.

BOOTH 3

"EEG Studies and the Use of Tranquilizer Drugs in the Care of Children with Reading, Speech, and Adjustment Problems in School"
Homer F. Weir, Robert L. Anderson

Rockford Memorial Hospital, Rockford, Illinois.

Studies have indicated the presence of abnormal cerebral rhythms in children having academic and adjustment difficulties in school and at home. A summary of EEG findings and results of tranquilizing therapy in these children will be presented.

BOOTH 4

"Bronchial Mucus in the Postoperative Period"
James Graham, H. Neale Barnes, and Alan S. Rubenstein

Springfield Rural Urban Clinic, Springfield, Illinois.

Elimination of tracheobronchial mucus is essential during the postoperative period to prevent bronchial plugging. A significant reduction in the incidence of atelectasis and pneumonitis can be accomplished. The program is approached from the medical, surgical and endoscopic points of view. Teamwork between internist, surgeon and endoscopist is the key. Bronchial physiology and function are shown in their relation to clinical management. Charts, drawings and photographs are used. A portable endoscopic setup for emergency transportation to the patient's room is demonstrated in the exhibit.

BOOTH 5

"Functional Constipation: Diagnostic and Therapeutic Considerations"
Frederick Steigmann, Milton Miller

Hektoen Institute for Medical Research of the Cook County Hospital, Chicago, Illinois.

With the aid of diagrams, a review of the different types of chronic (functional) constipation will be presented. The different substances and regimens used for relief of this type of constipation will be presented and discussed on the basis of their physiological and pharmacological activities. The development of, and clinical and laboratory observations on a new substance helpful in the management of chronic constipations will be described. The pharmacological basis for the activities of this new substance will be presented, and the effect of it will be shown by roentgenogram charts.

BOOTH 6

"Dermal and Epidermal Melanocytes"
Arnold A. Zimmermann and Samuel W. Becker, Jr.

Departments of Anatomy and Dermatology, University of Illinois, College of Medicine, Chicago, Illinois.

Twenty-eight transparencies of enlarged photomicrographs are mounted in cut-outs of a central and 2 side-panels. They are illuminated by fluorescent tubes. The material for this study was obtained from skin specimens of 100 Negro abortions. Most of the transparencies illustrate distribution patterns of melanocytes in spreads of split-skin preparations. The central panel portrays the earliest identified phases of human melanoblasts and melanocytes as far back as the 10th week of pregnancy. All the evidence points to their derivation from the neural crest, of which a diagrammatic representation is given. Clinical illustrations of pathological conditions of both dermal and epidermal melanocytes are also illustrated.

BOOTH 7

"Benign Diseases of the Pancreas"
Charles B. Puestow, W. J. Gillesby

Veterans Administration Hospital, Hines, Illinois.

Exhibit consists of central moulage showing in color the pancreas and its nerve supply. There are two panels on each side with nine colored photographs of specimens, X-rays and procedures. There are two end panels consisting of six similar illustrations with accompanying text. X-rays are shown in sepia, photographs in actual color and drawings of operation in vivid colors with black backgrounds.

BOOTH 8

"Tension States in Office & Hospital Patients"
Edmund Jacobson

Laboratory for Clinical Physiology, Chicago, Illinois.

Office and hospital patients generally show signs and symptoms of physiological tension states which are absent as a rule in persons without complaints. Graphic demonstrations with control tests as made with the integrating neurovoltmeter will be exhibited. Evidence is presented that neuromuscular tension states underlie symptomatology in functional nervous conditions and to some extent also in organic diseases including coronary infarction, hypertension and peptic ulcer. X-ray films, cardiograms and other clinical laboratory charts will carry details of particular maladies. Visiting doctors will be given a visual demonstration on themselves of their tension states.

BOOTH 9

"Regulation of Physical Activity in Management of Chronic Disease."
Edward E. Gordon

Michael Reese Hospital, Chicago, Illinois.

Regulation of physical activity is an important principle in the management of chronic disease. It applies permanently to conditions of impaired pulmonary function with consequent reduction of work capacity. Regulation may be advisable during convalescence when, after prolonged rest, in bed, "de-conditioning" phenomena supervene. In cardiac disease control of the intensity of physical effort is necessary. Grading of stress is still part of the management of the tuberculosis patient. In paraplegia due to any cause it has been shown that some patients so disabled are unable to meet the energy demands of ambulation even for moderate distances. An extensive list of energy costs is available, a fact not generally known to the medical profession. The exhibit is designed to present values, derived from the author's investigations and from the literature, which are inherent in activities of daily living, work and play. It is hoped they will help the practitioner decide in a given case which activities can be safely allowed and which interdicted.

BOOTH 10

"A New Anticolic Therapeutic Agent"
M. B. Andelman, Lester Nathan, Lawrence Breslow, Harold Gerber

Belmont Community Hospital, Chicago, Illinois.

Charts and Graphs Demonstrate Results of Study of 126 Cases.

BOOTH 11

"Sex Chromatin in Sexual Anomalies"
Joseph H. Kiefer, Ira Rosenthal, Elizabeth McGrew, I. Pat Bronstein.

University of Illinois, College of Medicine. Chicago, Illinois.

The exhibit describes the place of X and Y chromosomes in the inheritance of sex and the determination of sex chromatin in the diagnosis of sexual disorders.

BOOTH 12

"Maxillo-Facial Injuries"
Robert M. Booth

Springfield, Illinois.

Maxillo-facial injuries; twenty-five 8 x 10 color photographs.

BOOTH 13

"Gynecologic Surgery — Illustrations, Discussions of Technique, Pitfalls and Complications"
Walter J. Reich and Mitchell J. Nechtow

Cook County Hospital, Cook County Postgraduate School, Chicago Medical School, Chicago, Illinois.

This exhibit deals with the more common problem of cysto-urethrocele and rectocele which are repaired by many physicians in general practice as well as in general surgery and in specialty. Vaginal hysterectomy and total abdominal hysterectomy are illustrated and discussed as to the choice of approach, selection of case, preoperative preparation of the patient and how to avoid blood loss and other complications. The cervical "stump" is always a problem in management and as it may be the seat of carcinoma, the technique of its removal and how to avoid complications is discussed. The surgical removal of Bartholin cyst is illustrated, various methods are discussed and the prevention of serious hemorrhage is pointed out. Dilatation and curettage is illustrated and discussed, how to avoid perforation of the uterus and various indications and contraindications are brought out. The illustration and discussion of the vesico-vaginal fistula and the creation of an artificial vagina are illustrated and discussed. In all of these problems, practical discussions and emphasis is put on effective techniques, how to avoid serious blood loss, recurrence of the original pathology and other complications.

BOOTH 14

"Brucellosis in Industry"

John M. Coleman, Cornelius M. Annan

Mercy Hospital, Stritch School of Medicine. Chicago, Illinois.

Exhibit is displayed on cards and photographs depicting differential diagnosis, treatment and results of 90 cases of brucellosis.

BOOTH 15

"Hypothermia In Cardiovascular Surgery"

M. Sadove, J. Levin, O. C. Julian, W. S. Dye, J. H. Olwin

Veterans Administration Hospital, Hines, Illinois.

Demonstration of our technique of hypothermia, showing indications and scope of the methods.

BOOTH 16

"Alopecia Capitis: General Etiologic Survey" (A Practical Teaching Classification).

Julius E. Ginsberg, Chicago, Illinois

Bruce Bairstowe, Waukegan, Illinois

Northwestern University Medical School, Chicago, Illinois.

Large kodachrome prints with charts demonstrating the common, as well as some of the less common types of baldness seen by physicians, with suitable signs and inscriptions to make them of practical teaching value. Classification is one prepared by exhibitors to make the teaching of this subject simpler than it has been.

BOOTH 17

"Perinatal Mortality Pathology"

Frederick H. Falls and Charlotte S. Holt

Illinois State Department of Public Health, Chicago, Illinois.

This exhibit will be comprised of drawings, sculptures and plastic carvings to scale and letter charts indicating the chief causes endangering the lives of the intrauterine fetus near term. These will be depicted under the titles of Asphyxia, Trauma, Infections, Metabolic Diseases, Erythroblastosis Fetalis, Toxemias, Hemorrhages, Anomalies, Anesthesia and Prematurity.

BOOTH 18

"Electromyography in Clinical Medicine"

A. A. Rodriquez, Y. T. Oester, J. J. Fudema and J. A. Fizzell

Stritch School of Medicine of Loyola University, Chicago, Illinois.

Educational exhibit to show application and mechanics of electromyography.

BOOTH 19

"Does Your County Have a Full-Time Health Department?"

Harold K. Fuller, Illinois Public Health Committee

Illinois State-wide Public Health Committee, Springfield, Illinois.

This exhibit is provided primarily to show the relationships which exist between the full-time county health department and the local practicing physician. It includes photographs, 2″ x 2″ slides which will be continuously projected showing county health department services. Reading material in the form of pamphlets, pocket size books, and fliers will be available.

BOOTH 20

"Utilization of Toys in the Treatment of Crippled Children"

Elizabeth Jameson

The Illinois Association for the Crippled, Inc., Springfield, Ill.

Variety of toys showing use in occupational therapy programs and group play activities in treatment of crippled children in Illinois Easter Seal Centers.

BOOTH 21

"Exfoliative Cytology in the Detection of Early Cancer"

John A. Rogers

American Cancer Society, Illinois Division, Inc. Chicago, Illinois.

A three-panel exhibit demonstrating exfoliative cytology in the diagnosis of early cancer.

BOOTH 22

"Help for Hearts"

Peggy Pentz, Jack Grimes

Illinois Heart Association & Chicago Heart Association, Springfield & Chicago, Illinois.

Display of professional education materials and equipment available from Heart Associations.

BOOTH 23

"Rehabilitation's Debt to Medical Science"

Otto L. Bettag

Illinois Division of Vocational Rehabilitation Springfield, Illinois.

Background exhibit board featuring role of advances in medical science in expanding employment opportunities for disabled persons, particularly the severely disabled. The exhibit also includes disabled persons at work demonstrating the special skills they have as the result of vocational rehabilitation.

BOOTH 24

"The Scope of Occupational Therapy in the State of Illinois"

Fred Sammons

Illinois Occupational Therapy Association, Chicago, Illinois.

Three panels, 4′ x 6′. Main back panel identifies cities in Illinois which have occupational therapy clinics. Side panel identifies the Occupational Therapy school at the University of Illinois, College of Medicine. Side panel identifies the National Occupational Therapy Association.

BOOTH 25

"Muscular Dystrophy"

Toby Cohen

Muscular Dystrophy Associations of America, Inc.. New York, N.Y.

Exhibit shows what muscular dystrophy does; various aspects of the disease, common forms and diagnosis.

BOOTH 26

"Rehabilitation — The Modern Medical Approach to Disabling Illness"

Carl Nusbaum

Rest Haven Rehabilitation Hospital, Chicago, Illinois.

Photographic portrayal of rehabilitation techniques and services. Display of adaptive and assistive devices used by patients with handicaps.

PROGRAM
of the
TWENTY-NINTH ANNUAL MEETING
of the
WOMAN'S AUXILIARY
ILLINOIS STATE MEDICAL SOCIETY

May 21, 22, 23, 1957
Hotel Sherman, Chicago

All members and wives of physicians are cordially invited to attend Convention — to participate in the business session and to enjoy the social functions.

PROGRAM
REGISTRATION

Lobby Floor, Sherman Hotel

Tuesday, May 21 ..... 8:30 a.m. to 4:00 p.m.
Wednesday, May 22 ... 8:30 a.m. to 4:00 p.m.

Hostesses will welcome Members and Guests in the Hospitality Room.

PRE-CONVENTION SCHEDULE

Tuesday, May 21

Pre-Convention Board Meeting. Room 107 ..... 9:30 a.m. to 10:30 a.m.

Reference Committee Meetings

Mrs. Albert T. Kwedar, General Chairman

I. Reports of Officers and Directors. Room 106 ..... 10:30 a.m. to 11:00 a.m.

Mrs. Gregory Carey, Chairman

II. Reports of Councilors. Room 107 ..... 11:00 a.m. to 11:30 a.m.

Mrs. Charles L. Wunsch, Chairman

III. Reports of Committees. Room 106 ..... 11:30 a.m. to 12:00 noon

Mrs. H. Kenneth Scatliff, Chairman

CONVENTION PROGRAM
Tuesday, May 21

George Bernard Shaw Room

Formal opening of the Twenty-ninth Annual Meeting ..... 1:00 p.m.

Mrs. Robert E. Dunlevy, President, presiding

Invocation ..... The Rev. Dr. G. Weldon Gatlin, Western District Superintendent, Rock River Conference of The Methodist Church

Pledge to the Flag ..... Mrs. Harlan English, Director, Woman's Auxiliary to the American Medical Association

Pledge of Loyalty ..... Mrs. Nicholas G. Chester, President-Elect

Welcome .....
Mrs. Richard E. Westland, President, Woman's Auxiliary to the Chicago Medical Society
Response ..... Mrs. William A. Herath, Immediate Past President, Woman's Auxiliary to the Rock Island Medical Society
Report of Credentials and Registration Committee ..... Mrs. Henry Christiansen, Chairman
Reading of Convention Rules of Order ..... Mrs. George Hoffman, Parliamentarian
Adoption of Convention Program
Announcement of Reference Committee Appointments
Appointment of Committee on Courtesy and Resolutions
Appointment of Election Committee
Appointment of Reading Committee
Greetings from the Illinois State Medical Society ..... F. Garm Norbury, M.D., Chairman, Advisory Committee
Convention Announcements .....
.. Mrs. S. M. Hubbard, Convention Chairman
Report of the Joint Revisions Committee .....
..... Mrs. Lee N. Hamm, Chairman

Twilight Memorial Service
Old Chicago Room
Immediately following first delegate session
Mrs. C. L. Bennett, conducting
Miss Edna Michael, harpist
Mrs. John S. Curtis, soloist

All members of the Convention are invited to The Public Relations Dinner of the Illinois State Medical Society .....
..... 6:00 p.m. George Bernard Shaw Room
Speaker ..... Mr. Paul Jones, Director of Public Relations, National Safety Council

THE BEAU BELLE BALL

Bal Tabarin ..... 9:30 p.m. to 12:30

An evening of friendliness and fun with music, dancing and entertainment for doctors, doctors' wives and exhibitors.

Host: The Illinois State Medical Society
Hostess: The Auxiliary

Wednesday, May 22

Continental Breakfast
Hospitality Room ..... 8:00 a.m. to 9:15 a.m.
honoring
Mrs. G. Henry Mundt
Founder and First President of the Woman's Auxiliary to the Illinois State Medical Society
and
Mrs. James P. Simonds
Honorary Emeritus Publications Chairman of the Woman's Auxiliary to the American Medical Association

SECOND DELEGATE SESSION

George Bernard Shaw Room ..... 9:30 a.m.
Auxiliary Accomplishments .....
.....County Presidents reporting from:
District 1. Councilor, Mrs. Robert Borrowman. Counties: Boone, DeKalb, JoDaviess, Kane, Lake, Stephenson and Winnebago.
District 3. Councilors, Mrs. Joseph Cari, Mrs. Eugene T. McEnery and Mrs. George L. Pastnack. County: Cook.
District 5. Councilor, Mrs. Darrell H. Trumpe. Counties: Logan, McLean, Sangamon and Tazewell.
Program Emphasis .....
.... Mrs. Fred C. Endres, First Vice President
Public Relations .....
..... Mrs. William Somerville, Chairman
Legislation . Mrs. B. E. Montgomery, Chairman
A.M.E.F. Mrs. Richard E. Westland, Chairman
Auxiliary Accomplishments, continued .....
..... County Presidents reporting from:
District 7. Councilor, Mrs. Herbert Schoonover. Counties: Christian, Effingham, Macon and Marion-Clinton.
District 9. Councilor, Mrs. Morris Zelman. Counties: Jefferson-Hamilton and Saline.
District 11. Councilor, Mrs. Allen S. Watson. Counties: DuPage, Kankakee and Will-Grundy.
Emphasis on Recruitment ..... Mrs. Earl S. Leimbacher, Chairman, Introduction
Job Opportunities allied to medicine .....
..... Mrs. S. Glidden Baldwin

Luncheon

The Assembly Room ..... 12:30 p.m.
Introduction of Speaker .... Mrs. Robert Hart
Speaker .... Dr. Nicholas Nyaradi, Chairman, Department of Economics, Bradley University, "The Fifth Freedom"

THIRD DELEGATE SESSION

George Bernard Shaw Room ..... 2:30 p.m.
Auxiliary Accomplishments, continued .....
..... County Presidents reporting from:
District 2. Councilor, Mrs. Charles LeSage. Counties: Bureau, LaSalle, Livingston, and Whiteside-Lee.
District 4. Councilor, Mrs. Dan Morse. Counties: Henry, Knox, Mercer, Peoria, Rock Island and Warren.
District 6. Councilor, Mrs. George Vernon. Counties: Adams and Madison.
District 8. Councilor, Mrs. W. F. Lamkin. Counties: Champaign, Coles-Cumberland, Edgar and Vermilion.
District 10. Councilor, Mrs. G. H. Edwards. Counties: Alexander, St. Clair, Belleville Branch in St. Clair County.

Program Emphasis
Mental Health .....
.... Mrs. B. Smith Hopkins, Jr., Chairman
Civil Defense . Mrs. Newton Du Puy, Chairman
Reports of Reference Committees .....
..... Mrs. Albert Kwedar, General Chairman
I ..... Mrs. Gregory Carey, Chairman
II ..... Mrs. Charles L. Wunsch, Chairman
III ..... Mrs. H. Kenneth Scatliff, Chairman
ANNUAL DINNER OF THE ILLINOIS STATE MEDICAL SOCIETY ..... 7:00 p.m.

Thursday, May 23
FOURTH DELEGATE SESSION

George Bernard Shaw Room ..... 9:30 a.m.
Report of Courtesy and Resolutions Committee ..
..... Mrs. Warren W. Young, Chairman
Final Report of Credentials and Registration Committee
Presentation of the Budget for 1957-1958 ....
.... Mrs. Harlan English, Finance Chairman
Report of the Nominating Committee .....
..... Mrs. Carl E. Sibilsky, Chairman

Election of Officers

New Business

Convention Announcements

INSTALLATION LUNCHEON
with
Fashions by the Marquette Shops
Sheraton-Blackstone Hotel
The Mayfair Room 1:00 p.m.
honoring
Past Presidents of the Woman's Auxiliary to the Illinois State Medical Society
and
Mrs. Robert E. Dunlevy. Mrs. Nicholas G. Chester
Installation of Officers ..... Mrs. William Raim

Post-Convention Board Meeting ..... 4:00 p.m.
Gold Coast Room, Hotel Sherman
Mrs. Nicholas G. Chester, presiding

CONVENTION COMMITTEES
General Chairman
Mrs. Samuel M. Hubbard

HONORARY CHAIRMEN
Mrs. C. Elliott Bell
Mrs. Walter C. Bornemeier
Mrs. Frank H. Fowler
Mrs. Edwin S. Hamilton
Mrs. H. Close Hesseltine
Mrs. G. Henry Mundt
Mrs. Frank B. Norbury
Mrs. Joseph T. O'Neill
Mrs. Lester S. Reavley
Mrs. Norman L. Sheehe
Mrs. F. Lee Stone

COURTESY AND RESOLUTIONS
Mrs. Warren W. Young
Mrs. Eugene T. McEnery
Mrs. Norman L. Sheehe

CREDENTIALS AND REGISTRATION
Mrs. Henry Christiansen
Mrs. Gregory Carey
Mrs. W. W. Davidson
Mrs. Raymond E. Davies
Mrs. E. F. Dietrich
Mrs. V. E. Engelman
Mrs. Robert E. Field
Mrs. Rudolf V. Grimmer
Mrs. R.F.K. Jordan
Mrs. Alex J. Jovois
Mrs. John W. Koenig
Mrs. R. E. Miltenberger
Mrs. Fred M. Sheehan

ELECTION
Mrs. W. J. Wanninger
Mrs. Newton Du Puy
Mrs. J. K. Erffmeyer
Mrs. Carl E. Sibilsky
Mrs. N. A. Thompson

EXHIBITS
Mrs. James M. McDonnough
Mrs. Newton Du Puy
Mrs. Fred C. Glenn
Mrs. O. J. Rabe
Mrs. Wendell Roller
Mrs. Charles W. Stigman
Mrs. Frank Wall, Jr.

FAVORS
Mrs. M. G. Farinacci

HOSPITALITY
Mrs. Joseph S. Lundholm
Mrs. Neal D. Crawford
Mrs. C. Elliott Bell
Mrs. Wilbur L. Bowen
Mrs. Carl Clark
Mrs. Method L. Duchon
Mrs. Arthur I. Edison
Mrs. I. B. Ferrias
Mrs. Francis X. Graff
Mrs. Fernly Johnson
Mrs. Edward J. Kinney
Mrs. B. K. Lazarski
Mrs. Charles A. McClelland
Mrs. Clarence E. McClelland
Mrs. Armand J. Mauzey
Mrs. Paul F. Norbet
Mrs. Joseph T. O'Neill
Mrs. Lester S. Reavley
Mrs. Henry L. Schmitz
Mrs. Frederick Tice
Mrs. Robert Trapp

HOSPITALITY FOR SPECIAL GUESTS
Mrs. H. Close Hesseltine

HOUSE
Mrs. George L. Pastnack

INFORMATION

Mrs. Matthew E. Uznanski
Mrs. Richard E. Westland
Mrs. Nathaniel Baskind
Mrs. William F. Bartelt
Mrs. Robert Dessent
Mrs. Edward C. Helfers
Mrs. John Brown Jacobs
Mrs. J. L. Marks
Mrs. Clement Michet
Mrs. J. S. Schriver
Mrs. J. Emil Romano
Mrs. George Scupham
Mrs. Charles W. Stigman
Mrs. Joseph C. Stuart
Mrs. W. J. Wanninger
Mrs. August Wendell

INSTALLATION OF OFFICERS

Mrs. William Raim

MEMORIAL SERVICE

Mrs. C. L. Bennett
Miss Edna Michael, Harpist
Mrs. John S. Curtis, Soloist

PAGES

Mrs. Leonard J. Houda
Mrs. Sherman C. Arnold
Mrs. Silvio Del Chicca
Mrs. David Effron
Mrs. Norbert Klucikowski
Mrs. Alfred Pagano
Mrs. Frederick Roos
Mrs. Mitchell A. Spellberg
Mrs. Frank Wall, Jr.

PRESS AND PUBLICITY

Mrs. John W. Koenig
Mrs. Carl E. Sibilsky

READING

Mrs. E. M. Egan
Mrs. Walter C. Bornemeier
Mrs. Maurice M. Hoeltgen

REFERENCE

Mrs. Albert T. Kwedar

I. Reports of Officers and Directors

Mrs. Gregory Carey
Mrs. C. Spencer Bond
Mrs. Richard H. Bowman
Mrs. Rosario C. Drago
Mrs. F. L. Eihl
Mrs. J. Michael Linden, II
Mrs. F. N. Orr
Mrs. James F. Ross
Mrs. G. J. Sciaraffa
Mrs. Gordon Sprague

II. Reports of Councilors

Mrs. Charles L. Wunsch
Mrs. J. Lewis Bailen
Mrs. S. J. Goldhaber
Mrs. George P. Guibor
Mrs. Lewis A. Hare
Mrs. Morris Lang
Mrs. W. E. Rideout
Mrs. William F. Sargent

III. Reports of Committees

Mrs. H. Kenneth Scatliff
Mrs. David A. Bennett
Mrs. William Blender, Jr.
Mrs. Dale Caveness
Mrs. Edward G. Ference
Mrs. Louis Kappel
Mrs. Donald E. Sloan
Mrs. Howard E. Spafford

TICKETS

Mrs. Wendell Roller
Mrs. W. W. Baumgartner
Mrs. Henry Berchtold
Mrs. Thomas Carney
Mrs. J. K. Erffmeyer
Mrs. B. K. Lazarski
Mrs. H. J. Poterucha
Mrs. Henry C. Scholer
Mrs. Edward G. Warnick
Mrs. Martin Woloski

TIMEKEEPERS

Mrs. William Somerville
Mrs. Walter Grigg
Mrs. Nicholas Mennite
Mrs. Harry A. Mittleman
Mrs. Arthur James Peters
Mrs. F. M. Reis
Mrs. Paul E. Ross
Mrs. Herbert Schoonover
Mrs. C. Paul White

THE BEAU BELLE BALL

Mrs. Harlan English
Mrs. Donald D. Spicer
Members of the Vermilion County Auxiliary

CONTINENTAL BREAKFAST

Mrs. Edwin S. Hamilton
Mrs. Robert Borrowman
Mrs. Joseph Cari
Mrs. G. H. Edwards
Mrs. W. F. Lamkin
Mrs. Charles LeSage
Mrs. Eugene T. McEnery
Mrs. Morris Zelman
Mrs. Dan Morse
Mrs. George L. Pastnack
Mrs. Herbert Schoonover
Mrs. Darrell H. Trumpe
Mrs. George Vernon
Mrs. Allen S. Watson

LUNCHEON, MAY 22

Mrs. W. R. Freeman
Mrs. Leo Roseman
Members of the Champaign County Auxiliary

INSTALLATION LUNCHEON, MAY 23

Mrs. W. B. Werner
Mrs. R. V. Grimmer
Members of the Tazewell County Auxiliary

American board of obstetrics and gynecology

Applications for certification (American Board of Obstetrics and Gynecology), new and reopened, for the 1958 Part I Examinations are now being accepted. All candidates are urged to make such application at the earliest possible date. Deadline date for receipt of applications is September 1, 1957. No applications can be accepted after that date.

Candidates for admission to the examinations are required to submit with their application, a typewritten list of all patients admitted to the hospitals where they practice, for the year preceding their application, or the year prior to their request for reopening of their application. This information is to be attested to by the Record Librarian of the hospital or hospitals where the patients are admitted and submitted on paper 8½x11". Necessary detail to be contained in the list of admissions is outlined in the bulletin and must be followed closely.

Current bulletins outlining present requirements may be obtained by writing to the Secretary's office, Robert L. Faulkner, M.D., American Board of Obstetrics and Gynecology 2105 Adelbert Road, Cleveland 6, Ohio.

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The American-Korean Foundation

The American-Korean Foundation and the United States Army Medical Service have announced the discontinuation of their joint project of shipping medical books contributed by individual physicians, medical schools, hospitals and state and local medical societies to Korea.

Books should not be sent to the Sharpe General Depot in California as in the past for facilities no longer exist for packing and transshipping to Korea.

In making the announcement, Howard A. Rusk, M. D., President, American-Korean Foundation said, "the response of physicians and medical groups throughout the country for our appeal for books for Korean medical schools has been so generous that further contributions are not needed." As a result of this program, Dr. Rusk stated, over 77 tons, valued at $76,000, of medical texts, references and periodicals have been shipped to Korea for distribution to Korean medical schools.

Driving a car

Dr. Lamperiere read a paper on leisure activities involving speed. The desire for speed, she said, was an expression of man's dissatisfaction with his limitations and the frustrations of his personal life, and spectators derived at secondhand a similar satisfaction. In both cases the reaction was one of immaturity, a compensation for feelings of inferiority and of inadequacy as adults. For most people, driving a car undoubtedly liberated these compensatory mechanisms and this largely explained why people who are normally most tolerant and patient in their daily life became aggressive and discourteous on the road. Driving capacity varied greatly in the same individual according to his psychological and physical condition. In fatigue, alcoholism, or states of anxiety or preoccupation, a driver's reactions might be profoundly altered; an almost trancelike state could be produced in these circumstances, and inattention was a common cause of accidents. Sometimes a driver's aggression was not directly toward others: an unconscious desire for self-punshiment might lead to accidents and even occasionally represent a suicidal attempt. In some cases an accident had relieved severe anxiety or guilt obsessions, showing that it played the role of punishment and absolution. These instinctive reactions explained why legislation was generally so ineffective in preventing accidents. Lack of attention or concentration was by far the commonest cause of accidents, particularly among motorcyclists. Few accidents were due to mechanical faults or deficiencies. The prevention of accidents, therefore, is above all a question of repressing unfavorable instinctive impulses. Drivers need educating to the point where they would consider it as immoral to transgress the driving code as to kill or steal. *Mental Health Conferences in Berlin. British M.J. Sept.* 8, 1956.

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The overall picture

Above all, the thinking must be large scale and comprehensive. When you deal with a problem which concerns the welfare of 165,000,000 Americans, thinking naturally has to be along broadest lines. It is just as easy to think big as it is little. *Edward L. Bernays, The Engineering of Consent. Indust. Med. June* 1956.

THE P. R. PAGE



Edward A. Uzemack, Director of Public Relations

One of the more common faults in public relations was highlighted recently by Ed Kandlik, financial editor of the Chicago Daily *News*. It was brought out in his commentary on corporate annual reports, which he described as "masterpieces of ambiguity."

Unfortunately, this defect in the conduct of some public relations programs is not restricted to business and industry. We do run across some pretty good examples of ambiguity in pronouncements issued by the medical profession through its organizational representatives.

To spare feelings all the way around, I will cite the annual report examples attributed to a "LaSalle Street Wag" by Mr. Kandlik in his column. He describes these as the brain children of public relations directors or corporation secretaries.

Here is the list of how the statements are presented and how they might be, as reported in the Daily *News*:

"As a temporary measure and in order to increase your company's working capital, it has been decided to reduce the dividend this year. He (the "wag") suggests, earnings are down.

"Further substantial reductions in operating expenses have been made in recent months, despite the intensification of our sales and research activities. He proposes, 'there have been several layoffs.'

"In order for us to broaden our base of public ownership it has been decided to issue additional stock. He interprets, 'the stock will drop several points.'

"While it is true that synthetic discoveries may in the future affect our sales, your management feels that it is fully prepared and equipped to face these problems realistically and with confidence as to the outcome. He sums it, 'Our competition is way ahead of us.'

"Since its listing on the stock exchange, your company has noted with pride public interest as evidenced by a growing volume of its common share stocks, This might have been stated as, 'The directors are selling out.'

I wonder how many of you have seen resolutions, medical press releases and speeches loaded with similar attempts to hedge and to qualify.

New Reprints Available —

The A.M.A.'s Public Relations Department now has available for medical society distribution reprints of two recent magazine articles dealing with different aspects of medicine:

WHAT GOES ON IN A DOCTOR'S HEART? — deals with a doctor's personal feelings about sickness and death. Reprinted from the January, 1957, *Redbook*.

THEY'RE BRINGING THE DOCTOR BACK TO MAIN STREET — describes the success several rural communities have had

(with the help of physician placement services) in attracting doctors. Reprinted from *Reader's Digest*, January, 1957.

These reprints may be obtained by writing to the Public Relations Director, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

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Annual Assembly in Otolaryngology

The Department of Otolaryngology, University of Illinois College of Medicine, announces its Annual Assembly in Otolaryngology from September 30 through October 6, 1957. The Assembly will consist of an intensive series of lectures and panels concerning advancements in otolaryngology, and evening sessions devoted to surgical anatomy of the head and neck and histopathology of the ear, nose and throat.

Interested physicians should write direct to the Department of Otolaryngology, 1853 West Polk Street, Chicago 12, Illinois.

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Arterial graft

Fifty-nine patients with occlusion of the aortic or iliac arteries, or both, have undergone operation. There have been two hospital deaths among the 47 patients undergoing resection and grafting, giving a mortality of 4 per cent. One patient died of uremia and one of coronary occlusion and myocardial infarction. Sympathectomy alone should not be relied upon to do more than increase the blood supply to the skin of the extremities. Of 47 patients suitable for insertion of a homograft, 40 were improved, an improvement in 85 per cent. Patients who preoperatively could walk only a block or less before having severe pains in many instances have been capable of unlimited activities postoperatively. *F. Henry Ellis, Jr., M.D. and John W. Kirklin, M.D. Aneurysm and Thrombotic Occlusion of the Abdominal Aorta. Postgrad. Med. Nov.* 1956.

Prevention of radiation dermatitis

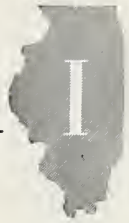
Prednisone in dosage of 10 to 20 mg. daily has been employed concomitantly with radiation therapy in treatment of basal and squamous cell epitheliomas. In a series of 16 patients, radiation dermatitis was minimized, and the degree of scarring seemed to be reduced with this regimen. Prednisone did not interfere with the normal tumor response to radiation. *Joseph B. Mathewson, M.D. Postradiation Inflammation Reduced by Prednisone. New York J. Med. Dec.* 15,1956.

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The psychiatric pendulum

Parents seem to have become increasingly fearful of disciplining, training, or frustrating children as a result of what is considered psychiatric teaching. Psychiatry has the responsibility for correcting such a misunderstanding. Psychotherapists who have not resolved their own dependency needs are in no position to help others with neurotic difficulties. Psychotherapy involves more than just arranging the world to accommodate itself to the patient (which occasionally needs to be done). The patient too has a responsibility for his illness and its treatment and must learn that life is characterized by the need to take some chances by dangers, difficulties, frustrations, and unknowns as well as pleasures, safety, comfort, and the familiar. The responsibility for meeting the need for psychiatric services belongs to all of medicine and not just to psychiatry. *Norman Q. Brill, M.D. Reflections on Contemporary Psychiatry. California Med. Nov.* 1956.

AT THE EDITOR'S DESK



THERE is no lack of dandruff remedies. Theradan (Bristol-Myers) is the latest and, according to a news release, "it has been remarkably effective in treating severe cases of dandruff resistant to other types of therapy . . . No hair loss was observed during 20 months of clinical trials involving over 150 cases, both men and women." What is more — it contains sarthionate!

The idea for the use of dioctyl sulfosuccinate (D.S.S.) in a cathartic came from a magazine article showing a duck sinking in water. The water had been made "wetter" by the addition of a small concentration of a synthetic agent that lowered the surface tension between the water and the oily material on the feathers. A group from Kansas City added Dorbane (1,8-dihydroxyanthraquinone) to D.S.S. and found the combination to be a satisfactory and flexible remedy for acute and chronic constipation. This product is on the market as Dorbantyl.

The U. S. Narcotics Commissioner, Harry J. Anslinger, told a Congressional subcommittee there is no evidence that the tranquilizers are habit-forming or addictive. Drug addicts never use them, which is something in favor of these mood boosters.

New tranquilizers are coming out every month. But they must be different to compete and within the past few months a normalizer (Pagatal-Warner-Chilcott) was announced. In its wake came Suavitil (Merck), an antiphobic. From the trade name we suspect that these pills are designed to make the user a bit more suave.

It is little wonder the public gets confused with our antics. The following appeared as a reprint from the Packer: Dr. Hunter McGuire Doles, a Norfolk physician, speaking in connection with National Heart Month, said ". . . his study of heart disease patients who had come to him, or under his observation, has led him to conclude that coronary heart disease can be prevented by eating fresh or canned vegetables." Dr. Doles continued: "Freezing vegetables destroys vitamin K, the important factor in the manufacture of prothrombin by the human body. The prothrombin prevents coronary thrombosis." He explained that farmers were seldom afflicted with heart disease until 1948 when they all acquired home freezers. Many studies have been done on prothrombin time in coronary thrombosis and, to your editor's knowledge, there is no evidence that the time is prolonged prior to the occlusion. Furthermore, coronary thrombosis antedates the home freezer and we wonder where John Hunter found his frozen foods when he collapsed in his yard from an attack of coronary thrombosis after an argument with his gardener.

On better authority comes information that will please our half million or more ulcer victims. According to a group from Peter Bent Brigham hospital, tests on 50 ulcer patients

showed that spices and highly seasoned foods did not delay the healing time of the peptic ulcer. They concluded that cinnamon, allspice, mace, thyme, sage, paprika, and caraway seeds had no harmful effect on the gastric mucosa. At last we can say that something has been found to add spice to the life of our ulcer patients. Several ulcer victims developed discomfort on taking black pepper, mustard, chili pepper, cloves, and nutmeg.

From Los Angeles comes a report that the person suffering from peptic ulcer may benefit from the tranquilizing effects of Serpasil. More spice.

An oldie: Avertin has come back into the news. It was reported from the Mayo Clinic as being the drug of choice in the sedative control of severe tetanospasm.

Kynex is Lederle's new long-acting sulfonamide. They say it is effective in the treatment of genitourinary infections, dysentery, respiratory infections, and rheumatic fever.

The University of Michigan used an electronic behavior testing apparatus to demonstrate that the meprobamates had no effect on driving ability. Whiskey did.

Organon introduced Nugestoral as a new product designed to prevent abortions. It is packaged for your prescriptions in boxes of 30 stripped tablets. Get them while they last.

A thinner, lighter microscopic lens makes it possible now for many legally blind persons to read. The aspheric curvature of the lens permits very strong lenses with high magnification.

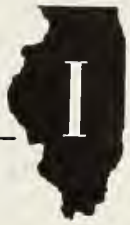
New York physicians are going to get social security coverage, or else. For the third time in five years, the Medical Society of the County of New York has passed a resolution urging Congress to include self-employed physicians in the next revision of the Social Security Act.

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If it's good, it's bad and visa versa

The anthropologist approaches the subject of motivation from another angle. He stresses the influence of culture in determining motivation. For example, Dr. Mead and others have pointed out that in northeastern United States, our culture is based on Puritanism. This tradition accounts for the common attitude that if something tastes good or feels good it is probably bad for you. The asafetida bag around the neck and the sulfur and molasses spring tonic owed their potency no doubt to this concept rather than to a controlled experiment. Dr. Mead further points out that in the southeast, where the culture derived not from Puritans but from a cavalier stock, these viëws do not hold to the same extent. Any of you with a tradition of upbringing stemming from New England will have heard many times that hot bread is not good for you. It is better when it is slightly stale (and, therefore, doesn't taste so good). This view does not prevail in the south. There, hot breads are preferred. They taste better and are, therefore, better than stale bread. The Californian insists upon enjoying health out of doors. In the east, until recently, sitting in the sun was thought sinful. People should be working. *Homer N. Calver. Motivation in Health Education. Indust. Med. June* 1956.

NEWS of the STATE



ADAMS

Personal.—Dr. A. A. Kuna, Quincy, has been accepted into membership by the Adams County Medical Society. At a recent meeting of the society, speakers were Drs. Arthur E. Perley, Waterloo, Iowa, and Joseph F. Montague, New York, on "Treatment of the Breast" and "The Puzzling Problem of Colitis," respectively.

The regular monthly meeting of the Adams County Medical Society at the Lincoln Douglas Hotel Monday evening, April 8, was preceded by a dinner in honor of the guest speaker, Dr. Frank R. Peterson of Cedar Rapids, Iowa, formerly Prof. and Head of the Department of Surgery, State University of Iowa. Dr. Peterson talked on precancerous lesions in various locations in the body and the importance of recognizing them early.

At the business session, the plans of the Special Poliomyelitis and the Public Relations Committees for an educational campaign to encourage the inoculation of all persons 6 months to 40 years of age were approved. These include a half hour panel discussion on poliomyelitis over both of Quincy's television stations; and the distribution of leaflets to all Quincy and Adams County physicians, dentists, pharmacists, and hospitals for their reception room tables and to enclose with their statements at the end of April. The society approved the plan of the Adams County Civil Defense Committee to organize the personnel for a 200 bed emergency hospital unit in Quincy, which is now in storage at the Illinois Soldiers and Sailors Home. This unit must be organized by June 15. The work will be in charge of the society's Disaster Committee of which Dr. Carl Pfeiffer is Chairman. The society voted to nominate Dr. Newton DuPuy as a member of the Council of the Illinois State Medical Society to represent the physicians from this district. After the meeting, Dr. Peterson was entertained informally in the home of Dr. Harold Swanberg.

The May 14 meeting of the society will be the annual public relations meeting, and all Quincy and Adams County nurses, medical assistants and technicians, hospital and medical society auxiliary members, public health personnel, pharmacists, dentists, and physicians be invited to attend. Dr. Theodore Van Dellen, Health Editor of the Chicago Tribune and Associate Professor of Medicine and Assistant Dean of the Northwestern University Medical School will be the speaker. He will talk on "Newspaper Medicine."

CHRISTIAN

Society News.—Dr. Robert M. Goodwin, Springfield, addressed the Christian County Medical Society, March 12, on "Housewife's Eczema-Dermatitis of the Hands", with special reference to its detailed management.

COOK

Student Assistantships in Psychiatry.—The department of psychiatry at the University of Chicago School of Medicine has received one of the fourteen grants from the Smith, Kline & French Foundation to enable it to set up four medical student assistantships. The assistantships will give advanced medical students opportunity to obtain a preview of psychiatric residency, according to Dr. C. Knight Aldrich, professor and chairman of the department of psychiatry. Under the department of psychiatry, the medical student assistants will attend classes and conferences, assist in treating a small number of selected patients, and receive individual supervision from the chiefs of service. Participation in research in collaboration with members of the department of psychiatry is also planned. The Smith, Kline & French Foundation is the independent philanthropic arm of Smith, Kline & French Labo-

ratories, Philadelphia pharmaceutical manufacturer. The grants are administered by a committee named by the American Psychiatric Association.

Hospital News.—On April 3, ground-breaking ceremonies were held at the Norwegian-American Hospital for a million dollar, five story addition to its present buildings at 1044 North Francisco Avenue. The new extension will provide quarters for sixty additional student nurses and sixty additional beds for patients. Patients will be housed on upper floors in air conditioned rooms to be equipped with individual oxygen service lines. The Ford Foundation contributed more than $91,000 toward the expansion project.

Alcohol Clinic.—Plans are under way to establish a new center for treatment of alcoholics by the Mayor's Commission on Rehabilitation. The center, which will be located on two floors of Chicago's Contagious Disease Hospital, 3026 South California Avenue, will be in charge of Dr. John Louis as medical director. Dr. James Vanderbosch, formerly on the staff of the Hartford (Conn.) Institute for Living, will head the psychiatric staff. It is hoped to have the center in operation by mid-May. About fifty patients will be accommodated in the project, which will be purely experimental. According to the Chicago Daily News, the commission was set up to help the city's derelict population. The city's budget includes a $121,000 appropriation for a staff.

Satire Features Northwestern Reunion.—On May 11, the annual medical faculty-alumni reunion of Northwestern University Medical School was held at the Furniture Club of America. Immediately after dinner, the annual musical-comedy staged by medical students and student nurses from Passavant and Chicago Wesley Memorial Hospitals was presented at Thorne Hall. Titled "Quo Vadis Medicus?, '57 Go Med, Co-ed?", the presentation was a satire on what happens when women take over the field of medicine. Music, lyrics and the story were entirely student written. Faculty adviser for the play was Dr. Harold L. Method, then president-elect of the medical division of the Alumni Association. Another feature of the reunion was the presentation of Golden Certificates to the class of 1907.

Lectures on Healthy Emotional Development.—Recent lectures in the Seventh Annual North Shore Health Resort Lecture Series on the medical practitioner's contributions toward healthy emotional development were Drs. Robert W. Laidlaw, chief, division of psychiatry, The Roosevelt Hospital, on "Marriage Counseling, and C. Knight Aldrich, professor and chairman of the department of psychiatry, University of Chicago School of Medicine, "Problems of Adulthood."

Hemophilia Clinic Opens.—On March 22, the first hemophilia clinic in the Midwest was opened at Grant Hospital, under the medical direction of Dr. Dorothy Welker, who is also in charge of the pediatric service. Other members of the staff include Dr. Henry Apfelbach, orthopedist, Joseph G. Mondo, D.D.S., and Mrs. Hazel Small Jones, R.N. The clinic, which is open every other Friday, is being sponsored by the Midwest Chapter of the National Hemophilia Foundation, 472 Deming Place, Chicago 14. The chapter, composed almost exclusively of hemophiliac families, was launched in Chicago in 1950 by Mr. Clifford T. Lyon, himself a hemophiliac. It was founded to provide aid, comfort and education for persons afflicted with the condition.

Personal.—Cerebral palsy clinics will be held by Dr. Meyer A. Perlstein for the Jamestown School for Crippled Children in Jamestown, N.D., June 3-4, and for the Minnesota Society for Crippled Children in Duluth, Minn., July 22-23.

Physician Honored on Sixtieth Birthday.—Dr. Rudolph Dreikurs, professor of psychiatry, Chicago Medical School, was guest of honor at a tea, marking his sixtieth birthday. Those sponsoring the affair included The Community Child Guidance Center, the Alfred Adler Institute and the Individual Psychology Association. The party also marked the publication of Dr. Dreikurs' new book, "Psychology in the Classroom."

New Directions in Psychotherapy.—A new series of lectures opened at the University of Chicago recently: April 2, "Psychosomatic Medicine: Current Developments", George H. Pollock, M.D., staff member, Chicago Institute of Psychoanalysis; April 9, "Client-Centered Therapy: Current Developments"; Desmond S. Cartwright, assistant professor, department of psychology, University of Chicago; April 23, "Bioanalytic Therapy: Current Developments"; Jules H. Masserman, M.D., professor of neurology and psychiatry, Northwestern University Medical School; May 7, "Personality Complexity and Therapeutic Outcome: Evidence From Projective Tests", William E. Henry, associate professor and chairman, Committee on Human Development, University of Chicago; April 30, "An Integrated Approach to the Treatment of Schizophrenia: the Work of Dr. Julius Steinfeld", Tom M. Sawyer, M.D., medical director, Forest Sanitarium; May 14, "New Trends in Psychotherapy With Borderline Children", Rudolf Eckstein, Ph.D., training analyst, Topeka Psychoanalytic Institute; May 21, "New Adlerian Approaches to Interaction", Rudolf Dreikurs, M.D., professor of psychiatry, Chicago Medical School; May 28, "Utilizing the Family in Successful Therapy", Virginia Satir, consultant, Psychiatric Residency Program, University of Illinois; and June 4 "An Anthropological Approach to Personality Disorganization", James S. Slotkin, associate professor of social sciences, the University of Chicago.

DU PAGE

Course in Radiologic Aspects of Civil Defense.—Under the direction of Drs. Claude R. Snead and Gus Ormbrek, a course in the radiological aspects of civil defense is being conducted Tuesday eve-

nings by the Radiological Section of the Elmhurst Civil Defense Unit. The sessions are held in the Elmhurst Municipal Building. Other participants are Drs. Harold W. Gaut, Harvey Patt and Earl Hathaway, and subjects include atomic structure, radiologic phenomenology, fundamentals of radioactivity, radiation detection instruments and radiation monitoring, and principles of radiologic safety and protecting the atomic worker.

Personal.—Dr. Earl A. Hathaway, Elmhurst, consultant to and former director of the Health Division, Argonne National Laboratories, participated in a symposium on radioactive materials, effects of radiation and related subjects, a feature of the meeting of the National Association of Mutual Casualty Companies and Federation of Mutual Fire Insurance Companies held in Chicago recently.

KANE

Dr. Klein Goes to Peoria.—Dr. Ernest S. Klein, assistant superintendent of Elgin State Hospital, has been transferred to the Peoria State Hospital, where he will be superintendent. His address is now 7101 South Adams Street, Peoria.

LAKE

New Members.—Dr. Eugene Pitts, 1324 North Sheridan Road, Waukegan, has been accepted into membership of the Lake County Medical Society on a transfer from the Racine County (Wis.) Medical Society. Another new member is Dr. Harry W. Hoegemeier, 535 Brainerd Avenue, Libertyville.

Society News.—Members of the Lake County Medical Society were guests of the staff of Lake Forest Hospital, April 18, to hear Dr. David Cugell, associate in medicine at Northwestern University Medical School, discuss "Pulmonary Function Tests."

LOGAN

Society News.—The Logan County Medical Society was addressed at the Hotel Lincoln in Lincoln, March 21, by Dr. Raymond Eveloff, Springfield, on "Security and Discipline in Children."

MADISON

Society News.—"Medical Management of the Problem Alcoholic" was the subject of Dr. Edwin H. Schmidt, assistant in the department of neurology and psychiatry, St. Louis University School of Medicine, at a meeting of the Madison County Medical Society at the Madison County Sanatorium, Edwardsville, recently.

Personal.—Dr. Richard Yoder has been accepted into membership of the Madison County Medical Society on transfer from the Colorado State Medical Society.

PEORIA

Society News.—"Common Disorders of the Adult Urinary Tract" were discussed by Drs. H. B. Henkel, Jr., and Grant Johnson, both of Springfield, before the Peoria Medical Society, April 16.

ST. CLAIR

Society News.—At a meeting of the St. Clair County Medical Society in Augustine's Restaurant, Belleville, April 4, the program featured the showing of the film "Case of the Doubting Doctor."

SANGAMON

Society News.—Dr. Keith S. Wilson, assistant professor of clinical medicine, Washington University Medical School, St. Louis, addressed the Sangamon County Medical Society, April 4, on "Hypersensitivity to Common Drugs."

VERMILION

Personal.—Dr. C. A. Ramey, Hoopeston, has been accepted into membership of the Vermilion County Medical Society.

WHITESIDE

Society News.—At a recent meeting of the Whiteside and Lee county medical societies in the Miami Hotel, Sterling, Lieut. Comdr. John H. Ebersole, M.C., U. S. Navy, discussed medical problems aboard a nuclear submarine. According to Dr. G. J. Pohly, publicity chairman of the Whiteside County Medical Society, Dr. Ebersole gave a most interesting and informative lecture showing how the submarine Nautilus demonstrated a superior offensive power. He also stressed the point that the same nuclear principles could be and are now in the process of being adapted to peace time industry.

GENERAL

Out of the Shadows.—Titled "Out of the Shadows," a report has been released by Portal House of the Chicago Committee on Alcoholism covering its activities for the year 1956. The booklet, attractively illustrated, tells briefly the history of the committee and reviews the problem of alcoholism. A total of eighty-six cases was handled during the year, including thirty-six new cases. Thirty-three cases were closed. Patient counseling sessions during the year totalled 1,215; family counseling sessions, 63, and group therapy meetings, 28. Of $56,979.73 expended during the year, $34,219.14 went for treatment; $14,471.59 for education; $6,217.30 for research, and $2,071.71 for administration.

Former Chicago Radiologist Awarded Gold Medal.—Dr. Hollis E. Potter, former Chicago radiologist now retired and living in Stuart, Fla., has been awarded the Gold Medal of the American College of Radiology for notable contributions to this medical specialty. Dr. Potter, besides making outstanding contributions to radiologic research, also contributed the ultimate improvements to the "Potter-Bucky" diaphragm, making the device workable. The diaphragm is a piece of x-ray equipment holding down scattered radiation. The results are better x-ray films, according to the American College of Radiology.

DEATHS

Irwin W. Bach*, Beverly Hills, California, formerly of Champaign, who graduated at Rush Medical College in 1912, died March 23, aged 71.

Samuel R. Barker*, Chicago, who graduated at Rush Medical College in 1921, died March 29, aged 60. He was a co-founder and chairman of the board of Roosevelt Memorial Hospital.

Lewis B. Bell*, Sr., Chicago, who graduated at Northwestern University Medical School in 1911, died March 24, aged 72. He formerly was a professor of clinical surgery at the Chicago Medical School.

Irving L. Chesne*, Chicago, who graduated at Loyola University School of Medicine in 1919, died April 1, aged 65. He was a member of the board of the Medical Alumni of Loyola University's Stritch School of Medicine.

Ray C. Drury, Oak Park, who graduated at Northwestern University Medical School in 1922, died March 25, aged 60. He was a member of the staff of St. Anthony de Padua Hospital, Chicago.

Gordon B. Fauley*, Chicago, who graduated at Northwestern University Medical School in 1930, died March 29, aged 57. He was a member of the staff of the Norwegian American Hospital.

Helen B. Flynn, Chicago, who graduated at the College of Physicians and Surgeons, School of Medicine of the University of Illinois, in 1906, died September 15, aged 74.

Jesse R. Gerstley*, Chicago, who graduated at Rush Medical College in 1909, died March 16, aged 70. He had been chairman of the Pediatric Department of Michael Reese Hospital, a governor of the Institute of Medicine, president of the Chicago Pediatric Society and of the Michael Reese Interns' Alumni Association.

Curtis A. Haines*, Chicago, who graduated at the College of Medicine and Surgery, Chicago, in 1909, died recently aged 74.

Addie Clark Hood, retired, Cicero, who graduated at Jenner Medical College in 1901 died March 26, aged 85.

Frederick C. Jacobs, Chicago, who graduated at Northwestern University Medical School in 1912, died recently aged 69.

Livingston E. Josselyn*, North Chicago, who graduated at the University of Chicago School of Medicine in 1932, died April 1, aged 52. He was associated with Abbott Laboratories.

Robert N. Lane*, retired, Gibson City,, who graduated at Rush Medical College in 1903, died February 27, aged 80.

Milton A. Nix*, Princeton, who graduated at Northwestern University Medical School in 1910, died April 5, aged 75. He was past president of the North Central Medical Association.

Charles H. Phifer*, Chicago, who graduated at the University of Illinois College of Medicine in 1902, died March 27, aged 77. He was a past president of the Chicago and Illinois State Medical Societies, and emeritus professor of surgery at the University of Illinois.

Harry Burton Roberts*, Highland Park, who graduated at the University of Illinois College of Medicine in 1903, died March 26, aged 86. He was a former president of the Highland Park Hospital Board and the Lake County Medical Society.

Herman Schmidt*, Okawville, who graduated at Marion-Sims College of Medicine, St. Louis, in 1895, died March 2, aged 83.

Manly H. Shipley, retired, Des Plaines, who graduated at Western Reserve University School of Medicine, Cleveland, in 1915, died March 5, aged 70. Until his retirement in 1949, he had practiced medicine in Rockford for many years.

Eric Steiner*, Cicero, who graduated at Deutsche Universität Medizinische Fakultät, Prague, Czechoslovakia, in 1922, died in the St. Anthony de Padua Hospital, November 27, aged 59.

Hal P. Wells*, Chicago, who graduated at Missouri Medical College in 1894, died March 27, aged 82.

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* Indicates member of The Illinois State Medical Society

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For further information, see S.K.F. literature.

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BOOK REVIEWS



FUNDAMENTS OF CLINICAL FLUOROSCOPY WITH ESSENTIALS OF ROENTGEN INTERPRETATION. Second Revised Edition by Charles B. Storch, M. D., Associate Attending Roentgenologist, Radiodiagnostic Department Beth-El Hospital, Brooklyn, New York. — 305 pages, Grune & Stratton, New York 1957 — $8.75.

The first edition was published in 1951. It was printed a second time in 1951 and again a third printing was in 1951, a fourth in 1953. This reprinting of the first edition speaks well indeed for the author's ability; and now comes a second edition revising the original text in many respects and adding many new features.

The first chapter deals with basic concepts of X-ray use. The mechanics are explained as well as the significance of the controls. The danger of X-ray is explained and the need for protection. The mode of protection for examiner and patient is amplified and means of obtaining this care is concisely stated. These elementary subjects are dealt with specifically and not abstractly; and this is surprisingly interesting. A newer concept, not yet fully developed is that of image intensification. The possibility of this one phase of fluoroscopy bids fair to increase its effectiveness in diagnosis many fold. This intensification of the image and cineradiagraph will add very greatly to the already invaluable aid of fluoroscopy in studying congenital heart disease, small bowel, intestinal obstruction, and gall bladder disease.

Dr. Storch does not portray fluoroscopy as a "final" and complete means of arriving at a diagnosis — but he pictures many variations in "positioning" the patient for making films, whereby facts are obtained that would have been missed entirely in just routine position for film exposure of the part being studied.

Diagnostic pitfalls are listed and explained; the method of avoiding them is carefully shown.

The author makes extensive use of illustrations, showing the findings of normal tissues and then alongside an abnormal finding. These cuts are well marked, pinpointing the specific area. The description accompanying the cuts is terse and clear.

This work is quite valuable for students, but for medical specialists and general practitioners this treatise on fluoroscopy is also very valuable and is highly recommended.

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REHABILITATION LITERATURE 1950-1955. A Bibliographic Review of the Medical Care, Education, Employment, Welfare, and Psychology of Handicapped Children and Adults.

Compiled by Earl C. Graham, Librarian and

(*Continued on page* 48)

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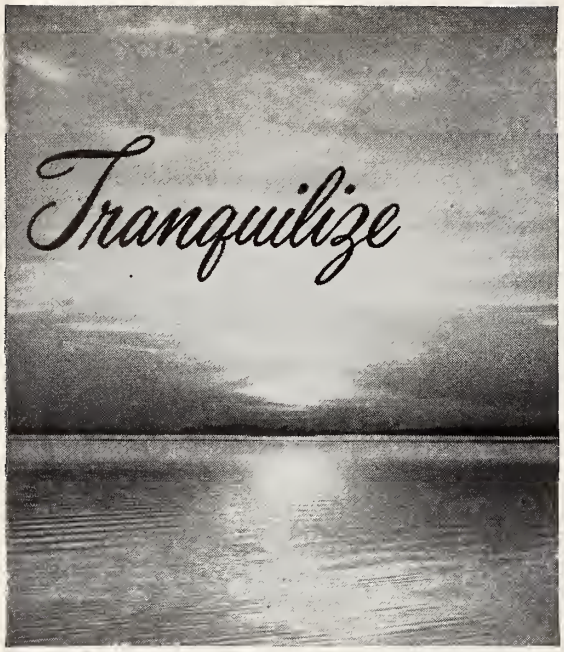
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references: 1. McDermott, W.: Ann. New York Acad. Sc. *65*:59 (Aug. 31) 1956. 2. Noyes, H. E.; Nagle, S. C., Jr.; Sanford, J. P., and Robbins, M. L.: Antibiotics & Chemother. *6*:450 (July) 1956.

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BOOK REVIEWS (Continued)

Marjorie M. Mullen, Assistant Librarian. National Society for Crippled Children & Adults.

The Blakiston Division, McGraw-Hill Book Company, New York - Toronto - London. 621 pages - $13.00.

This book is one all inclusive, new, rehabilitation bibliography. It indexes and annotates 5,214 periodical articles, pamphlets and books relating to the medical care, education, employment, welfare and psychology of handicapped children and adults.

For every professional worker in the field of services to the handicapped, this book is invaluable. For all who are interested in the handicapped, this volume presents a vast amount of information that is not only interesting but instructive, in the matter of diagnosis, of therapy and of prognosis.

C. P. B.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

NEW AND NONOFFICIAL REMEDIES: Containing descriptions of drugs evaluated by the Council on Pharmacy and Chemistry of the American Medical Association. An annual publication issued under the direction and supervision of the council. J. B. Lippincott Company, Philadelphia and Montreal.

THE FIGHT FOR FLUORIDATION: By Donald R. McNeil. Oxford University Press. New York. $5.00.

GUIDE TO MEDICAL WRITING: A practical manual for physicians, dentists, nurses and pharmacists. By Henry A. Davidson, M.D., Editor, Journal of the Medical Society of New Jersey. The Ronald Press Company, New York. $5.00.

PRINCIPLES OF UROLOGY: An introductory textbook to the diseases of the urogenital tract. By Meredith F. Campbell, M.S., M.D., F.A.C.S., Emeritus Professor of Urology, New York University. 622 pages. 319 figures. W. B. Saunders Company, Philadelphia and London. $9.50.

ALBERT SCHWEITZER: The story of his life. By Jean Pierhal. Philosophical Library, New York. $3.00.

BATTLE FOR THE MIND: How evangelists, psychiatrists, politicians and medicine men can change your beliefs and behavior. By William Sargant. Doubleday & Company, Inc., Garden City, New York. $4.50.

EXPECTANT MOTHERHOOD: By Nicholson J. Eastman, M.D., Professor of obstetrics in Johns Hopkins Uni-

(*Continued on page* 50)

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BOOKS RECEIVED (Continued)

versity and Obstetrician-in-chief to the Johns Hopkins Hospital. Little, Brown & Company, 34 Beacon Street, Boston 6. Third edition, revised. $1.75.

HUMAN DISEASE. By A. E. Clark-Kennedy. 272 pages. An account of the reactions of the individual to the risks which may overcome him. 85c.

LIVER, BILIARY TRACT AND PANCREAS: By Frank H. Netter, M.D., Edited by Ernst Oppenheimer, M.D. The Ciba Collection of Medical Illustrations. Volume 3, a compilation of paintings on the normal and pathologic anatomy of the digestive system. Commissioned and published by CIBA. 133 full-color plates with descriptive text; cross-referenced index of over 2000 items. New feature — bibliography of over 300 general and specific references. Sold at cost — $10.50.

CLINICAL CARDIOPULMONARY PHYSIOLOGY: Sponsored by the American College of Chest Physicians. Grune & Stratton, New York and London. $15.75.

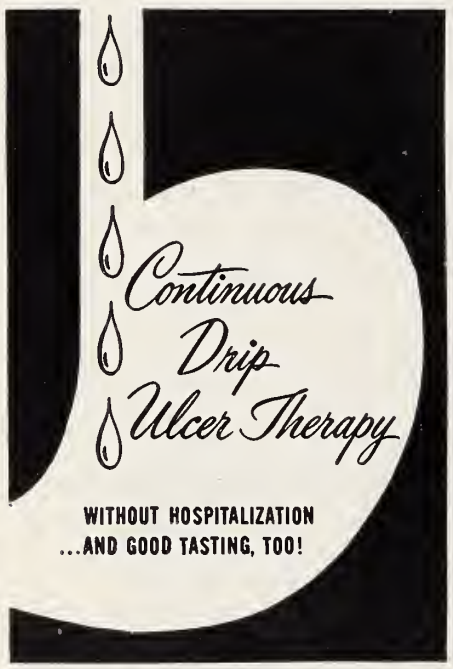
SYNOPSIS OF PATHOLOGY. By W. A. D. Anderson, M.A., M.D., F.A.C.P., F.C.A.P., Professor of Pathology, University of Miami School of Medicine; Director of Pathology Laboratories, Jackson Memorial Hospital, Miami, Florida. With 328 text illustrations and 12 color plates. Fourth edition. The C. V. Mosby Company, St. Louis. $8.75.

THE CARE OF THE EXPECTANT MOTHER. By Josephine Barnes, M.A., D.M. (Oxon.), M.R.C.P. (London), F.R.C.S. (England), F.R.C.O.G., Assistant Obstetrician and Gynaecologist, Charing Cross Hospital and Elizabeth Garrett Anderson Hospital; Surgeon, Marie Curie Hospital. Philosophical Library, New York.

MODERN OFFICE GYNECOLOGY. By George Blinick, M. D., F. A. C. S., Attending in Obstetrics and Gynecology, Beth Israel Hospital, New York City; Visiting Gynecologist, Harlem Hospital, New York City; Assistant Clinical Professor of Obstetrics and Gynecology, New York University College of Medicine; Diplomate, American Board of Obstetrics and Gynecology, and Sherwin A. Kaufman, M. D., F. A. C. S., Associate Attending in Obstetrics and Gynecology, Beth Israel Hospital, New York City; Medical Director, Planned Parenthood of Manhattan and the Bronx, New York City; Diplomate, American Board of Obstetrics and Gynecology. 47 illustrations. Lea & Febiger, Philadelphia. $4.50.

BASIC FOUNDATIONS OF ISOTOPE TECHNIQUE FOR TECHNICIANS. Edited by Williard C. Smullen, M. D., F. A. C. R., Radiologist in Charge, St. Mary's Hospital, Decatur, Illinois. Charles C. Thomas, Publisher, Springfield, Illinois, $4.75.

(*Continued on page* 52)



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*Steigmann, F., and Goldberg, E.: Ambulatory Continuous Drip Method in the Treatment of Peptic Ulcer, Am. J. Digest. Dis. *22*:67 (Mar.) 1955.

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BOOKS RECEIVED (Continued)

THE PRINCIPLES AND ART OF PLASTIC SURGERY. By Sir Harold Gillies, C.B.E., F.R.C.S., and D. Ralph Millard, Jr., M.D., Diplomate, American Board of Plastic Surgery, Assistant Clinical Professor, University of Miami School of Medicine. Chapter on Anaesthesia by Ivan Magill, C.V.O., F.F.A.R.C.S. Foreword by Jerome Pierce Webster, M.D., professor of clinical surgery, College of Physicians and Surgeons, Columbia University. 2 volumes. Little, Brown and Company, Boston and Toronto.

PROCEEDINGS OF THE THIRD NATIONAL CANCER CONFERENCE. Detroit, Michigan, June 4-6, 1956. Sponsored by American Cancer Society, Inc. and National Cancer Institute, U. S. Public Health Service. J. B. Lippincott Company, Philadelphia and Montreal. $9.00.

THE ROAD TO INNER FREEDOM—The Ethics. By Baruch Spinoza. Edited and with an Introduction by Dagobert D. Runes. Philosophical Library, New York, New York. $3.00.

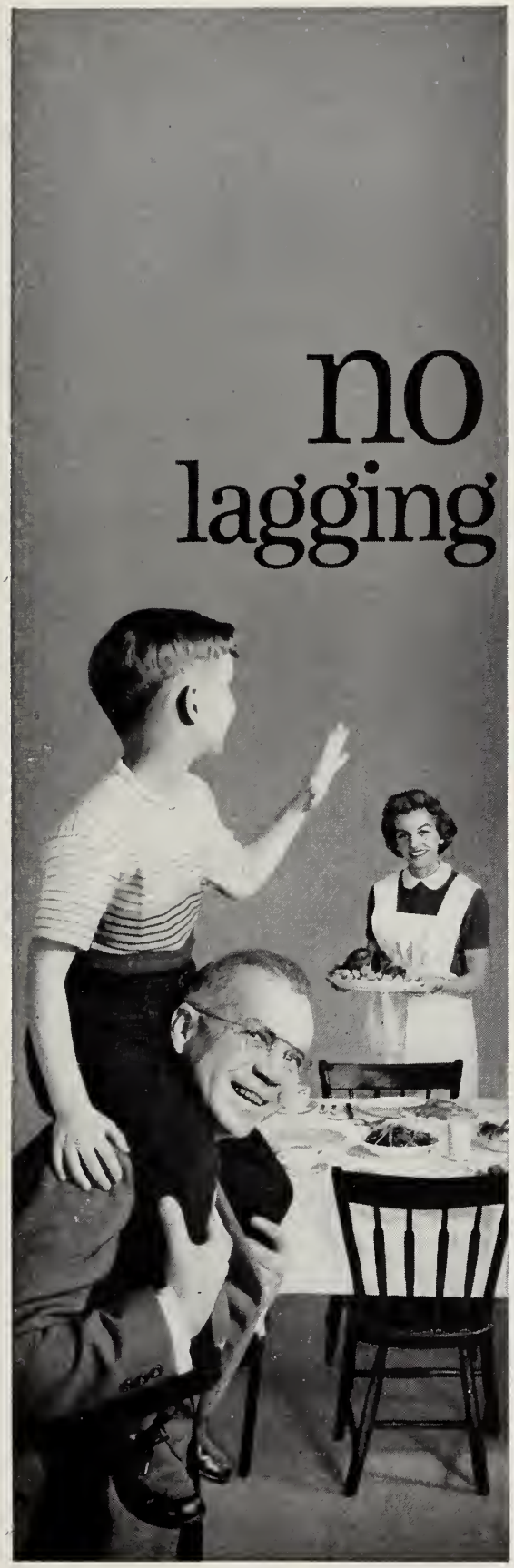
RHEUMATIC DISEASES, RHEUMATISM AND ARTHRITIS. By Heinrich G. Brugsch, M.D., F.A.C.P., Assistant Professor of Medicine, School of Medicine, Tufts University; Physician-in-Charge, Arthritis Clinic of The Boston Dispensary, a Unit of the New England Medical Center; Diplomate, The American Board of Internal Medicine. J. B. Lippincott Company, Philadelphia and Montreal. $10.00.

CLINICAL LABORATORY METHODS. By W. E. Bray, B.A., M.D., Consulting Laboratory Director, Martha Jefferson Hospital, Charlottesville, Virginia; formerly Professor of Clinical Pathology, University of Virginia and Director of Clinical Laboratories, University of Virginia Hospital. With 124 text illustrations and 18 color plates. Fifth Edition. The C. V. Mosby Company, St. Louis. $9.75.

EXPERIMENTAL PSYCHOLOGY AND OTHER ESSAYS. By Ivan P. Pavlov. Philosophical Library, New York. $7.50.

CLINICAL USE OF RADIOISOTOPES. By William H. Beierwaltes, M.D., Associate Professor of Internal Medicine and Coordinator, Clinical Radioisotope Unit, University Hospital, Ann Arbor, Philip C. Johnson, M.D., Assistant Professor of Internal Medicine and Chief, Radioisotope Unit, Veterans Administration Hospital, Oklahoma Medical School, Oklahoma City, and Arthur J. Solari, B.S., M.D. (Physics) Instructor in Radiation Physics, Department of Radiology, Radiation Physicist for Clinical Radioisotope Unit and Kresge Research Isotope Unit, University Hospital, Ann Arbor. 456 pages. 126 figures. W. B. Saunders Company, Philadelphia and London, $11.50.

PEDIATRIC CARDIOLOGY. By Alexander S. Nadas, M. D., F. A. C. P., Assistant Clinical Professor of Pediatrics, Harvard Medical School; Cardiologist, The Children's Hospital, Physician, Sharon Cardiovascular Unit, Children's Medical Center, Boston. 587 pages. 343 figures. W. B. Saunders Company, Philadelphia and London, $12.00.



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effective...A series of 500 cases of diaper dermatitis[1] was treated—with cure resulting in all but three infants. Wherever erythematous, intertriginous zones developed in the diaper region accompanied by the pungent odor of ammonia, treatment was instituted. Ammoniacal odor disappeared with gradual relief of symptoms. As a control, 50 healthy, normal infants were given prophylactic treatment. None developed ammonia dermatitis. PEDAMETH promises effective therapy!

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1. Goldstein, Louis S., Clinical Medicine *59*:455 (1952).

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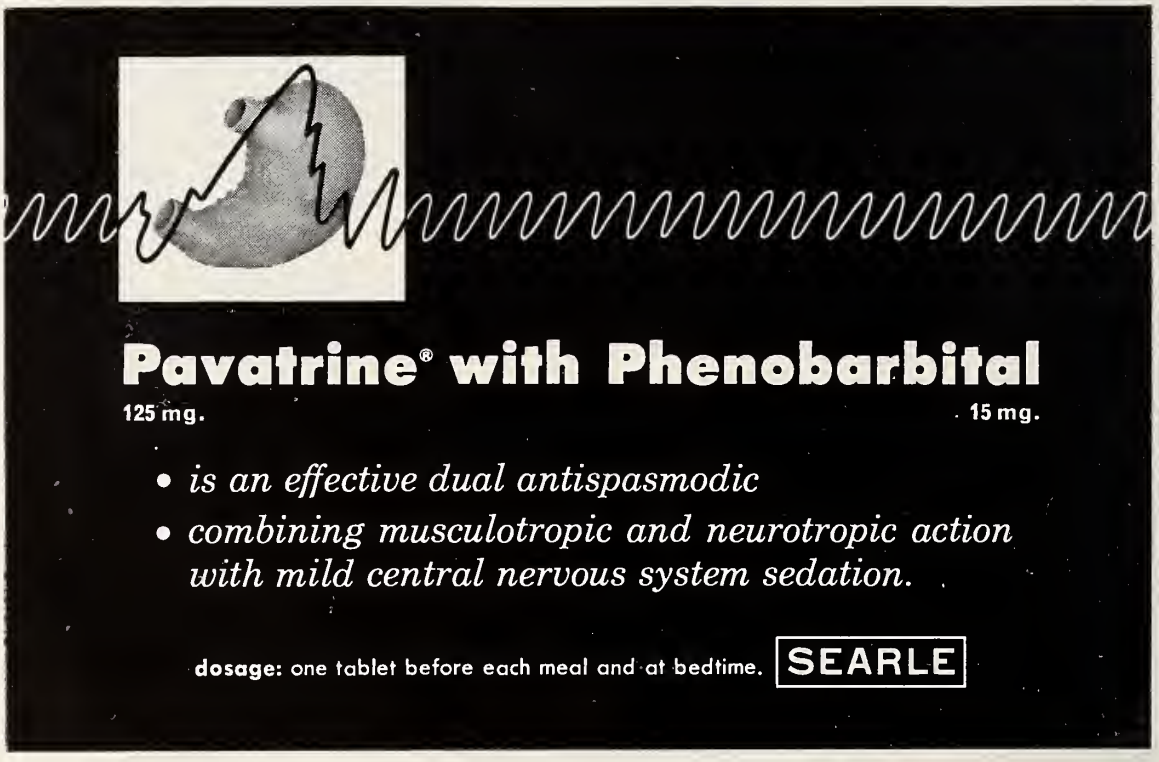
We are always learning new scientific truths. Since, presumably, there is only a finite amount of truth in science, the more we learn, the smaller the remaining dark area of ignorance. This suggests the hypothesis that eventually terra incognita will shrink to zero and there will be nothing more to learn. No one seriously expects this to happen and it is interesting to wonder why it won't. Take our own discipline, for instance; we have enough trouble mastering that so we will not speculate about ultimate truths in mathematics, botany, and atomic energy. Every disease has a cause but you can run down the index of any medical book and see lots of diseases of unknown cause. You would think that part of the progress of science would be the transfer of diseases from the unknown cause to the known cause column. And it is true, that for a few diseases that has happened. When it comes to knowing the effective treatment we have made vast progress on one line but this has simply shifted much of the traffic to the other line. Thus, we now save from death many people who suffer from septicemia, pernicious anemia, diabetes, and pneumonia. Actually, what we do is to postpone death, not conquer it. So we now have a skyrocketing incidence from other chronic diseases, particularly malignancies and cardiovascular disorders. And here we still have enormous areas of ignorance. It is as if there were a joker in the background who manufactured new areas of darkness every time we got some light into one of the old corners. It is, one suspects, the destiny of man ever to be confronted with impenetrable mysterious and unconquerable frontiers. And, fortunately, it is destiny too, to keep on trying to unwrap the enigma and cross the frontier. The mathematical formula apparently does not apply. As we open new areas to knowledge, we do not seem to reduce the total acreage of our area of ignorance. Somehow there is always another mountain to climb. *Editorial. The Shrinking Area of Ignorance. J. Med. Soc. New Jersey, Aug.* 1956.

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—*Eric Johnson*

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New journal of cardiology

P. A. Porter, Vice President of Yorke Group Publications, New York has announced that in January 1958 it will begin publication of the official organ of the American College of Cardiology. The new journal will be entitled The American Journal of Cardiology.

The Yorke Group also publishes the American Journal of Medicine, the American Journal of Surgery and the American Journal of Clinical Nutrition.

Editor of the new journal will be Dr. Simon Dack of New York. The publication will be devoted to clinical cardiology. Monthly departments on "What Is New In Cardiology" will be included.

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We do not need more national development, we need more spiritual development. We do not need more intellectual power, we need more spiritual power. We do not need more knowledge, we need more character. We do not need more law, we neeed more religion. We do not need more of the things that are seen, we need more of the things that are unseen.

—*Calvin Coolidge*

Home treatment of tuberculosis

What does a tuberculous patient need in the home? He needs the same sort of medical supervision that hospital patients get which means regular visiting and examination and availability of a physician in an emergency. X-rays and laboratory work need to be done. The patient needs drugs, some hospital equipment, and dressing perhaps. He needs supervised rest and graduated exercise, case work for himself and for the family, health education, diversional and recreational therapy as well as vocational and occupational therapy, dietary supervision, and physiotherapy in selected cases. These are all necessary, unreservedly available services in any good institution. *George A. Silver, M.D. Care of Tuberculous Patients in Organized Home Care Programs. Pennsylvania M.J. Dec.* 1956.

‹ ›

A little knowledge

The parents of most crying babies have much in common. They have been to a college where they have taken courses in psychology. They have designed their lives carefully. *David McL. Greely, M.D. Am. Pract. & Digest Treat. Dec.* 1956.

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1. Toverud, K. U.; Stearns, G., and Macy, I. G.: Maternal Nutrition and Child Health. An Interpretative Review, Washington, D.C., National Research Council, National Academy of Sciences, Bull. No. 123, 1950, p. 115.
2. Proudfit, F. T., and Robinson, C. H.: Nutrition and Diet Therapy, ed. 11, New York, The Macmillan Company, 1955, p. 271.
3. Martin, E. A.: Roberts' Nutrition Work with Children, Chicago, The University of Chicago Press, 1954, pp. 231-236.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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Management of esophageal cancer

There can be no doubt that with adequate radiation treatment, the primary focus in the esophagus can be controlled with considerable consistency. It is likely that the involvement of the regional lymph nodes, with very few exceptions, demarcates the borderline between curability and incurability by either surgery or radiation therapy. Our experience has shown that we are unable to control lymph node involvement secondary to epidermoid carcinoma by external irradiation. It is possible that in the presence of minor lymph node involvement, surgery in a certain number of incidences may succeed in eradicating the entire disease. The sharp drop of curability in the presence of lymph node invasion is well recognized in other cancers such as those of the breast and tongue. It appears justified that the patients in whom the likelihood of surgical resection with permanent control is nil or unreasonably small, may still receive equal palliation by adequate radiation therapy with considerably less morbidity inherent in the procedure. Restoration and maintenance of oral feedings could be accomplished in over 50 per cent of the patients treated with radiation. Complete or nearly complete primary freedom from symptoms (almost normal deglutition and radiological improvement of the passage) could be obtained in a very high percentage of the adequately treated patients. In many instances the patients were able to swallow up to the time of death, which in most cases was due to metastases and cachexia. The specific purpose of palliation in this type of cancer is the prevention of the misery of starvation. Gastrostomy has in general been abandoned as unsatisfactory. It prolongs life without comfort or happiness. Palliative results as measured by symptom-free survival (with restoration of esophageal function) after one, two, and three years, are the same following surgical resection with anastomosis or adequate roentgen therapy. *Case Discussions from the University of Louisville Hospital. J. Kentucky M.A. Sept.* 1956.

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They who give have all things; they who withhold have nothing.

—*Hindu Proverb*

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Choledochotomy

There are certain absolute indications for choledochotomy. They include:

1. The discovery by palpation of the duct of any suspicious lump suggesting stone.

2. Visualization of a filling defect suggestive of stone by operative cholangiography.

3. The presence of jaundice or the history of recent jaundice.

4. The presence of clinical cholangiitis.

5. An associated acute pancreatitis. In this case, decompression is accomplished by choledochostomy, but traumatic probing of the lower end of the bile duct must be avoided.

There also are several relative indications for choledochostomy including:

1. The presence of dilatation of the bile duct or thickening of its wall.

2. The presence of small stones within the gall bladder.

3. The presence of a thick-walled, contracted gall bladder.

4. Alteration of the bile in the common duct (obtained by aspiration).

5. Induration of the head of the pancreas.

George S. Bergh, M.D. Acute Cholecystitis and Choledocholithiasis. Minnesota Med. Oct. 1956.

‹ ›

The importance of serial electrocardiograms

Recently I observed three cases in which myocardial infarction was suspected on the basis of clinical findings, and electro-cardiographic substantiation was desirable. Serial tracings in these cases had to be continued to the sixth, 12th, and 20th days respectively before diagnostic tracings were recorded. Thus the importance of serial graphs is realized. Barker commented on the danger in basing a diagnosis on a single electrocardiogram taken on hospital admission. Diagnostic signs may be absent and if futher tracings are not made, the patient may be released. Rosenbaum warned that the physician may be falsely reassured when the first tracing is normal or the second shows no change. He emphasized that changes may be delayed and serial tracings should be continued. *Stephen L. Magiera, M.D. Late Electrocardiographic Changes in Acute Myocardial Infarction. Postgrad. Med. Oct.* 1956.

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Polio rehabilitation

The highlight of my trip to Copenhagen was my visit to the Blegdam Hospital. There I saw some 20 - odd patients with complete respiratory paralysis, the remaining casualties of the devastating polio epidemic of three years ago. At first glimpse it looked like a deep sea diving establishment; the room pulsed with the hissing and sighing of pumps, from each of which an airline went to a patient. But unlike the divers, the patients did not wear helmets; instead, the air tubes ended in tracheotomy cannulae, fitting snugly and tightly inside a human windpipe. Otherwise the patients were entirely free, untrammelled by box or cuirass. Their comfort has to be seen to be believed. Nursing is easy, with complete access to the whole patient and without the distress caused by opening the usual tank respirator. The patients are mobile. They can be moved about in a wheelchair. A small pump has been devised which attaches to the back of the chair, worked by a compressed air cylinder slung under the seat. On this, patients can be taken for walks through the streets or carried on trains so that all of them have been able to spend weekends with their families. Many of them have learned to phonate a few words during the inspiratory (positive-pressure) phase; it is virtually the pharyngeal speeeh of the laryngectomized. All of them have most severe peripheral paralysis also, so that the only useful movement left may be head movements or a tiny flick of one wrist. Much ingenuity has been shown in exploiting such residual power — for example, most of them can manipulate an electric typewriter, tapping the keys with a stick held between the teeth. The Danish government is offering free immunization against polio to all below the age of 40; it is not surprising that the acceptance rate is over 97 per cent. *In England Now. Lancet, Sept.* 15, 1956.

‹ ›

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The ward round arrived at the bed of a patient with a vesicocolic fistula. "Now," said the the chief, turning to Alfred, our student from Nigeria, "tell me what it means when a man makes a whistling noise passing his water." "It means he is happy, Sir," replied Alfred. *Lancet. Oct.* 27, 1956.





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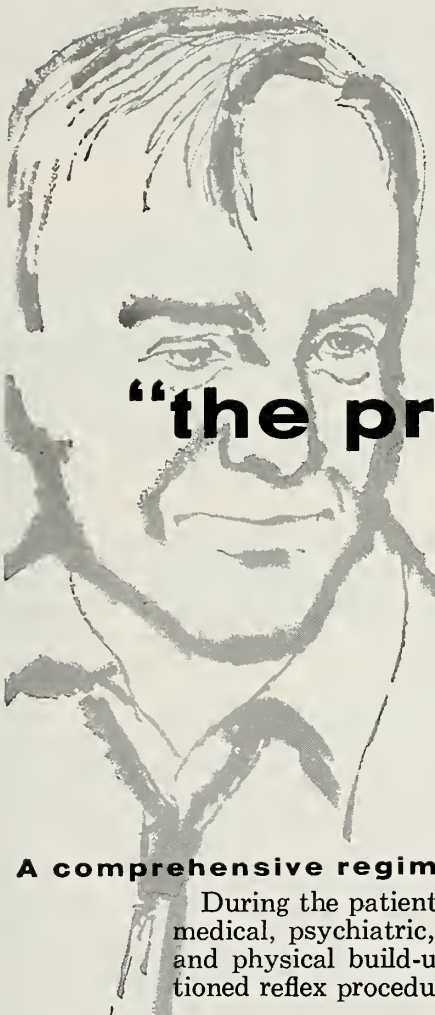
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‹ ›

A laugh is worth a hundred groans in any market.

—*Lamb*

Inactivity and obesity

Two groups of high school girls, 28 obese and 28 nonobese individuals of similar height, age, and grade, were compared in regard to physical maturation, food intake, and activity. The groups were found to differ in maturation, obese girls showing advanced development, i.e. earlier deceleration of growth in height, and earlier menarche. Activities were represented by a system of indices devised for this study. Both groups were found to be relatively inactive but the obese girls were significantly more so. When caloric intakes and activity indices were compared for each group to determine the salient energy factors in the development and maintenance of obesity, it appeared that on a statistical basis, inactivity was much more important than overeating. In fact, the caloric intake of the obese group was significantly lower than that of the nonobese group, with the relatively greater energy balance being consequently supplied by inactivity. *Mary Louise Johnson, D.Sc., et al. Relative Importance of Inactivity and Overeating in the Energy Balance of Obese High School Girls. Am. J. Clin. Nut. Jan-Feb.* 1956.

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*Eudaemonia is a feeling of well-being or happiness; in Aristotle's use, felicity resulting from life of activity in accordance with reason.

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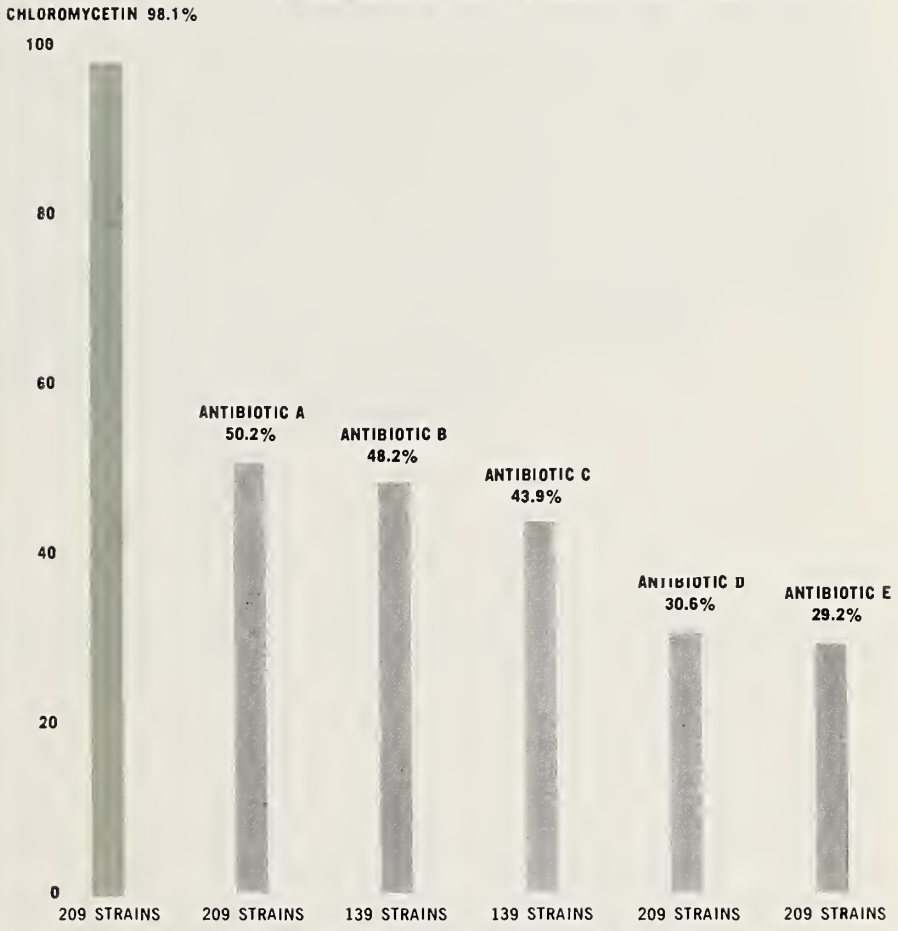
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The Month in Washington

Washington, D. C. — Again the Jenkins-Keogh plan is up for consideration in Congress. While there is no assurance it will be passed, or even get out of the House Ways and Means Committee, many sponsors of the legislation this year are united in one organization and are making themselves felt on Capitol Hill.

Briefly, this bill would allow any self-employed person to put a limited portion of his income into a retirement fund without paying income taxes on the money. Taxes would be paid when the money was received as pension or retirement.

Sponsors of the Jenkins-Keogh plan point out that it very definitely is not legislation to give a special tax advantage to one group of people. For one thing, every self-employed person would be eligible, from farmers to doctors and from opera singers to architects. For another, corporations since 1942 have been allowed to put money into retirement funds for their employees without payment of federal taxes on the money; the self-employed merely want the same consideration.

At various times the American Medical Association has led in the campaign for enactment of legislation of this type. Two years ago the House Ways and Means Committee voted to report it out, as part of a broader tax bill, but the committee never actually got around to sending the combined bill to the House floor.

Now the lead is being taken by a newly-formed American Thrift Assembly, or officially the American Thrift Assembly for Ten Million Self-Employed. In addition to the AMA, the new group has the support of American Dental Association, American Bar Association, and a score or more of other national organizations that represent the self-employed.

After the Congressional session was well under way, the ATA surveyed the political-legislative climate and found it favorable for Jenkins-Keogh. Then in early May the assembly asked its constituent associations to go to work. They were urged to have all members contact the House Ways and Means Committee with requests that the Jenkins-Keogh bill be reported favorably to the House floor. Assembly strategists are confident that if the committee hears from enough of the people who would be affected, it will approve the bill before adjournment. Then, if there isn't time for House action this year, that step can come next year.

Economy has been the main obstacle in the path of Jenkins-Keogh — the fear on the part of the Treasury Department that passage of the bill would mean a serious loss of income tax revenue. However, the Treasury has never denied that the bill is justified to equalize tax status for the self-employed in relation to corporation employees.

Answering the economy argument, the Assembly makes two points:

First, the set aside funds, invested in the country's economy, would stimulate business and develop far more in new income tax payments that it would cost.

Second, because the self-employed who retain their health rarely retire at any arbitary age,

(*Continued on page* 28)



the problem of the "vegetable" patient

The symptoms are all too familiar: apathy, paucity of ideas, repetition of vague complaints, sloppy appearance.

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*T.M. Reg. U.S. Pat. Off.

WASHINGTON (Continued)

many of them in the years past 65 would remain in a tax bracket not significantly lower than when they paid into the retirement fund.

NOTES

When Congress votes the money, the new home of the National Library of Medicine will be constructed at Bethesda, Md., near the National Institutes of Health and the Navy Medical Center. This site was selected by the board of regents at its second meeting.

At the request of Speaker Rayburn, the House Interstate and Foreign Commerce Committee has set up a special subcommittee with authority to find out if government agencies are expanding their operations beyond limits intended by Congress. The subcommittee expects to continue its investigations between the sessions of Congress.

The continuing national health survey is under way. Each month from now on, 140 Census Bureau interviewers will visit 3,000 homes, asking questions about illness and disability. On the basis of the data collected, the Public Health Service will publish national and regional reports on morbidity and mortality.

Because of his achievements in the advance of mental health, Dr. William C. Menninger has been selected by the U.S. Chamber of Commerce as "one of the great living Americans."

Because of widespread interest aroused by Senate hearings, there is considerable pressure for action before adjournment on legislation for some form of federal control over union welfare funds. One bill, by Senator Goldwater, would lay down strict procedures, including audits.

Also before Congress, but not making rapid progress, is a bill that would give the federal government control over amphetamines and barbiturates. Various types of bookkeeping and registration would be required, but physicians would be exempt from the requirements. It has administration support.

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The
ILLINOIS
Medical Journal

Official Journal of The Illinois State Medical Society

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Illinois Medicine — Off to A Big Second Century

F. Lee Stone, M.D., Chicago, President, Illinois State Medical Society

THE Illinois State Medical Society had a glorious first century under leaderships of men whose love for their profession made them go all out in their efforts so that the people of this state should enjoy the best possible health care.

They not only contributed to the medical progress of their times, but were a part of community life by participating in civic activities. We are proud to have them on our roll of honor.

In 1940, the Society embarked upon the second century of its existence. Those who have been at its helm since then have faithfully carried on the fine traditions of their predecessors. Thus, Illinois medicine is off to a good start toward another 100 years of accomplishments.

Time is too short to go into great detail of the works of the men who have headed the Illinois State Medical Society over the last 16 years. But, you may be interested in knowing who the presidents have been.

1940 James H. Hutton, a past president of the Chicago Medical Society, got the second century of the Illinois State Medical Society off to a good beginning. He presided over the House of Delegates in the Pere Marquette Hotel, Peoria, May 21. After the death of Dean D. J. Davis, Dr. Hutton took over the editorship of the second volume of the "History of Medical Practice in Illinois, 1850-1900." Following that he participated in many of the activities of the State Society, even up to the present day.

1941—The President was J. S. Templeton of Pinckneyville, whose achievements brought him honors on Ralph Edwards' "This Is Your Life" program and in 1953 his selection as the Illinois General Practitioner of the Year. He presided at the 1941 sessions of the House of Delegates in Chicago. The credentials committee certified 64 delegates from downstate and 57 from the Chicago Medical Society and 14 members from the Council, a total of 135.

1942—Charles Phifer, lately deceased, served this year. He was responsible for the development of the Chicago Medical Society's Clinical Conferences and Post-Graduate courses. Dr. Phifer was active throughout his public life with the medical care of public assistance recipients. The 102nd annual meeting was held in Springfield.

1943—E. H. Weld, who died last year, was president. He was the First District Councilor

Presented before General Assembly, Illinois State Medical Society, Annual Meeting, May 21, 1957.

for many years. His president's address at the annual meeting in Chicago was "The Future of Medicine." These were troubled years because they were war years.

1944—G. W. Post was President. He died in office and was succeeded by Robert Berghoff. Dr. Post, despite a cardiac condition, carried on to the last as he disliked a life of inactivity. His death occurred in front of his office in Chicago.

1945 and 1946—Everett P. Coleman of Canton and man of many scientific honors, served the Society for two years. This was due to the fact that the 1945 annual meeting was cancelled at the request of the government in order to reduce traveling. He carried on as president in 1946 and in his annual report he gave a very extensive talk on what had transpired in medicine in the two years.

1947—The President was Robert S. Berghoff, he of the silver tongue and leader in civic affairs as well as medicine. The 1947 annual meeting was held in the Palmer House, Chicago. In his report as President, he enumerated activities for the preceding year. His was a year when medicine staved off immediate socialization.

1948—Decatur is proud of the record of Irving H. Neece, who served his Society with distinction. Again the annual meeting was held in the Palmer House. The credentials committee certified 61 delegates from the Chicago Medical Society, 70 from downstate, 19 officers and members of the Council, a total of 150. In his annual report, his recommendations had a word to say on the medical student problem. He also said nursing education was in a critical position.

1949—Our own Percy E. Hopkins did himself and the Society credit. He is carrying on nobly as chairman of the Committee on Medical Service and Public Relations and other committees. In his annual message he said: "It seems to me that the last year will go down in the records as one of the most important periods in the history of American medicine. That refers not to scientific achievement as we would all prefer but rather to the social and economic relationships of the medical profession."

1950—Walter Stevenson died shortly after the completion of a successful term. The 1950 annual meeting was held in Springfield. Dr. Stevenson continued the fight against socialized medicine, pointing out that in the minds of all "do-gooders" in Washington this remained a major program.

1951—Harry M. Hedge handled the duties in a forthright manner. The annual meeting was held in the Sherman Hotel for the first time. We have been holding forth there ever since. In his annual report Dr. Hedge said let physicians continue their civic-mindedness and willingness to serve on local school boards, boards of health, as public officers, be active in church and church organizations.

1952—Kewanee gave us C. Paul White, who has a long list of achievements to his credit. In his Presidential report, Dr. White stressed that medical men should have citizenship responsibilities. "One recognizes that this should be indelibly impressed in the hearts and minds of every physician in the State of Illinois," he said.

1953—Leo P. A. Sweeney, man of many talents and much ability, was the President. His humor helped us to get over many trying situations. In his Presidential report, he expressed the thought that many changes and challenges nationally and at the state and local levels have occurred. Nationally, there was a mandate from the people to turn away from socialization and nationalization of our industries and services.

1954—The President was Willis I. Lewis, a capable executive and surgeon of ability. In his annual report, Dr. Lewis brought out the fact that he had spent much time and effort in behalf of medicine throughout Illinois as well as in the adjacent states. He also spent considerable time in the Monmouth office and made special mention of the employees there, which I heartily corroborate.

1955—Arkell M. Vaughn—Kelly to us—was President. A fine surgeon—also noted for his big cigars, oil wells and automobiles. In his annual report, he recommended that county society presidents and secretaries be invited to Council meetings to observe the Council deliberations. He also stimulated the sale of the second volume of the "History of Medical Practice in Illinois."

1956—My good friend and associate, F. Garm Norbury, the professor, was President. He can handle any situation. His credo was expressed in his annual report: "The dignity of man as an individual, the dignity of our honored profession, which over the centuries has put service above self, the thing we must maintain. As we



James H. Hutton



J. S. Templeton



Charles H. Phifer



E. H. Weld



Everett P. Coleman



Robert S. Berghoff



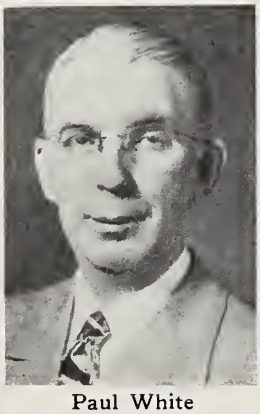
Irving H. Neece



Percy E. Hopkins



Harry M. Hedge



Paul White



Leo P. A. Sweeney



Willis I. Lewis



Arkell M. Vaughn



F. Garm Norbury



Edwin S. Hamilton



Harold M. Camp

take care of our patients, as we accept community, state and national responsibilities, thus do we show ourselves in our true light."

It has been my pleasure over the years to associate with fine men in the Council of the Illinois State Medical Society. They have dedicated themselves to seeing that medicine in this state is something of which we can be proud. The chairman and other Council members deserve great credit.

When it comes to steering our craft on a safe financial or policy course, we turn to Edwin S. Hamilton. The American Medical Association recognizes that ability, too, by depending on him for counsel.

Perhaps best known to our more than 10,000 members—and one who knows most of them personally—is Harold M. Camp, Secretary-Treasurer and Editor of the Illinois Medical Journal. He has served the Society with distinction for so many years that he has become to us the indispensable man.

The future is bright, indeed.

« « « » » »

Psychiatry in Peru

In this connection, Dr. Majluf and Dr. Chock deplored the fact that in Peru and throughout Latin America there are serious handicaps to the practice of psychiatry. In the upper economic strata the authoritarian father is not to be troubled about his children, and the subservient mother does not dare impugn his name by implying that their offspring have serious behavior problems that might need outside attention. In the depraved lower strata, poverty, illiteracy, and disease as well as Indian reserve and suspicion make many social services, let alone individualized psychotherapy, difficult or virtually impossible. In fact, many Indians, even when fairly paid and well treated, are willing to work for Spanish or foreign employers for at most a few weeks; after that they are content to return to their isolated mountain huts and terraces in unending flight from the ways of the conquistadores. In between, the middle classes, in whom alcoholism is rampant, furnish a variable and uncertain field of preventive or therapeutic psychiatric endeavor. *Jules H. Masserman, M.D. Psychiatry in Latin America. Quart. Bull. Northwestern U. Med. School, Spring* 1957.

Medical discoveries by nonmedics

Some of the great additions to medicine have come from nonmedical people. From the ministry such men are as follows: Stephen Hales, Gregor Mendel, Joseph Priestly, and Southwood Smith. The biologists include: Darwin, Curie, and Metchnikoff; amongst the astronomers we have Quetelet, Halley, and Servetus; and of the chemists such men as Lavoisier and Pasteur. In the same manner, fields outside of medicine have been adorned by physicians. In the field of philosophy we might mention John Locke, Moses Maimonides, and William James; in exploration, David Livingstone and Wilfred Grenfell; biology, Huxley; music, Borodin; literature, Tchekhov, Schiller, Rabelais, Goldsmith, and Weir Mitchell. We find such physicians as Botta and Dubois participating in the field of archaeology; in government, Clemenceau and Petty; military service, Leonard Wood; botany, Jacob Bigelow; geology, Woodward and Hutton; and Gatling and Guillotin who went on to become inventors. *Fredrick Stenn, M.D. A Rapid Survey of Medical Achievement. New Physician. March,* 1957.

Reticuloendotheliosis (Non-Lipid) in Infants and Children

HEYWORTH N. SANFORD, M.D., CHICAGO

THERE are a group of disorders occurring in children characterized by a proliferation of reticuloendothelial cells in the various organs. These cells are all phagocytic and occasionally contain an accumulation of lipids or cholesterol in their cytoplasm. It was once believed that this cellular response was an attempt to remove abnormal lipids formed elsewhere in the body, as the result of some disturbed lipid metabolism.

Certain conditions leading to hyperlipemia and hypercholestermia will cause cells of the reticuloendothelial system to respond and engulf such particles circulating in excess. This closely resembles histologically the appearance of reticuloendotheliosis. However, these secondary conditions are clinically different from those of reticuloendotheliosis.

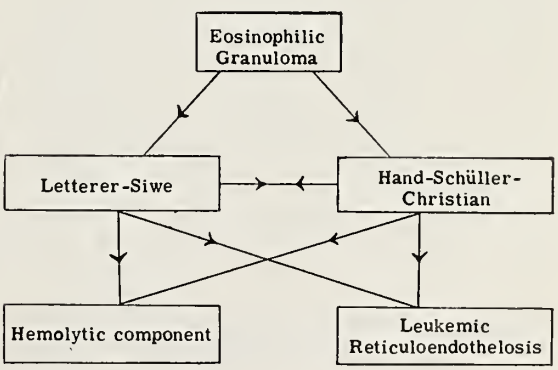
There also are two diseases that have a distinct and definite biochemical reason for this phagocytosis. These are Gaucher's disease, characterized by an accumulation of kerasin in the cells, and Niemann-Pick disease characterized by an accumulation of sphingomyelin. Such diseases are not considered in this series, but only those that have no lipid accumulations in their cells, although in some instances there may be an accumulation of cholesterol.

These diseases are also called granulomatous, or nonlipid reticuloendotheliosis. Their etiology is unknown. The pathological process involved is now thought to be a disturbance of the intrinsic metabolism involving the cells of the reticuloendothelial system. This process differs from the lipid form as seen in Gaucher's disease and Niemann-Pick disease in that there is a tendency for the formation of discrete granulomatous lesions rather than a diffuse infiltration. Lipid accumulations either do not occur or have not been recognized in the early stages. When they do develop, the lipid consists of cholesterol and cholesterol esters. Finally, in the more chronic form seen in older children, complete healing may occur and the lesion disappear with scar formation.

Letterer[1] in 1924 published the first detailed description of the infantile type, and ten years later Siwe[2] correlated the clinical findings with the pathological picture. Wallgren[3] in 1940 postulated that Letterer-Siwe's disease and Hand-Schuller-Christian's disease were the same fundamental pathological process with different histological phases, depending upon the chronicity of their respective course. He felt that the only essential difference was the storage of cholesterol in the reticuloendothelial cells of the latter disease. This would occur only if the disease had existed for some months and would not be found in Letterer-Siwe's disease because its rapid termination would not allow sufficient time for its accumulation.

A further condition was described by Ortani and Ehrlich[4] in 1941 as eosinophilic granuloma of bone. This was characterized by solitary granulomatous defects in bone, the principal

Interrelationships between reticuloendothelioses and certain related conditions



From the Department of Pediatrics, University of Illinois College of Medicine.

Presented before the Section on Pediatrics, 116th Annual Meeting, Illinois State Medical Society, Chicago, May 15-18, 1956.

histological cell being the eosinophil. Farber[5] suggested that this condition might represent a third manifestation of a basic pathological process such as reticuloendotheliosis.

In early infancy the disease pursues a rapid fulminating course, usually terminating fatally. In later infancy or early childhood chronicity, with eventual cholesterol accumulation, is the usual course. The third type, eosinophilic granuloma of bone, occurs in later childhood with the bone lesions containing the same fundamental process. In a number of instances there has been a transition from one type to the other. Furthermore, in some respects the reticuloendothelial proliferation behaves like a neoplasm when it occurs in infants and young children as it infiltrates various organs and progresses to a rapid and fatal conclusion.

Over a five year period from 1950 to 1955, at Research and Educational Hospitals, our admissions of children under 12 years of age totalled 2,859. During this time there were 11 admissions for nonlipid reticuloendotheliosis. In five infants, three boys and two girls, the disease began under one year of age; these cases conformed to the so-called Letterer-Siwe's type. In five children, four boys and one girl, the disease began after one year of age; these conformed to the Hand-Schuller-Christian type. There was one instance of eosinophilic granuloma of the bone in a boy that began after three years of age. This makes a total of 11 cases of reticuloendotheliosis (nonlipid) or a hospital incidence of 1 in 260.

In the younger age group, all followed a similar pattern. In four, symptoms began before 6 months of age, the earliest being at two months. The latest was 10 months of age. In three, there was a prodromal period of anorexia, loss of weight, and lassitude before the rash was noted, and in two the rash was the earliest symptom. The rash was present in all children. It appeared first on the face or scalp and spread to the trunk and limbs. It had a particular predilection for the hairline, neck, and inguinal regions. The earliest lesions were greasy and seborrheic-like, later changing to elevated maculopapular lesions about 2 to 3 mm. in diameter. These were dark red and suggested hemorrhagic vesicles but they blanched under pressure. Later, true petechial or larger hemorrhages were present. These lesions itched and would be scratched off, causing secondary infection.

Marked enlargement of the liver and spleen took place early. In one instance, it was noticed before the onset of the rash. While they were not as enlarged as in Niemann-Pick or Gaucher's disease, they were a good three fingers below the rib margin. They were present in all five children throughout the course of the disease and all showed generalized lymphadenopathy.

Fever ranging from 101° F. to 104° F. was present in all. It was present in the lower ranges at all times, and if intercurrent infections occurred it rose to the upper levels. All of the children gave a history of repeated respiratory infections at the beginning or as one of the first symptoms of the disease, and the entire course was characterized by repeated infections: upper respiratory, tonsillitis, otitis media, and mastoiditis. The infants showed poor resistance and infection would last much longer than in normal children.

Three of the infants showed roentgenographic evidence of infiltrations in the lungs, most marked in the hilar regions and they were not unlike tuberculosis or histoplasmosis. Two of the infants showed rarefied areas in the bones of the skull, and one child showed separation of the sutures.

All of the infants presented a hypoplastic type of anemia. The hemoglobin varied between 4 and 8 grams in every instance, and the red blood cells between 1,500,000 and 3,800,000. The white cells were within normal limits unless there was an intercurrent infection, when they would be elevated. All of the infants displayed hemorrhagic tendencies at one time or another, but their blood platelets were never under 140,000 except in one instance. In this boy they fell to 42,000 in a leukemic phase. All of the infants showed hypoplastic bone marrow. Two had reticulocytes of 10 to 15%; they also had a total bilirubin of 1.5 mg. to 2.5 mg., and fecal urobilinogen of 17.8 gm. to 49 mg.

These two infants presented a hemolytic phase which has been reported previously[6]. The diagnosis of this hemolytic process was based on the following findings. 1) normocytic, monochromic anemia, erratic and rapid in occurrence with no evidence of hemorrhage; 2) persistent reticulocytosis; 3) slightly elevated serum

bilirubin; 4) increased fecal urobilinogen; 5) erythroid hyperplasia of marrow; 6) in cell survival studies, one-third of the donor cells were destroyed in four days, and 7) response to adrenal steriod (ACTH).

The urine was normal in all of the infants, and the blood cholesterol was between 107 mg. and 190 mg. All of the infants had a steady downhill course with increase in anorexia, loss of weight, and lassitude. Hemorrhage or intercurrent infection terminated the picture. One child died of chicken pox. The average span of life varied between five and 18 months. Only one child in this series is still alive. She is 17 months old, the disease having run 12 months to the present time.

One of the infants whose symptoms began at 10 months had a rather marked anemia, with platelets reduced to 42,000. His peripheral blood showed 40% blast forms, and the bone marrow was considered leukemic. He was treated as a leukemia with puerenthal, aminopterin, and cortisone for several months. He had good remission and was sent home under continued treatment. He returned after three months with polydipsia and polyuria. Roentgenograms showed a separation of the sutures of the skull and an infiltrative process in the lung. His bone marrow showed typical histocytes and eosinophils, with hypoplastic anemia.

There were five children in which the first symptoms appeared after 1 year of age. The youngest was 16 months old and the oldest, 3 years. While all of these children had some loss of weight, anorexia, and various other complaints, none was acutely ill.

Only two of the children had any initial rash and one developed it later. This was a yellow, dry, scaly, papular eruption on face, trunk, and upper limbs. It was never conspicuous or diffuse. Two showed some enlargements of liver and spleen, and one developed enlargements later. All, however, had generalized lymphadenopathy. One had necrosis of the gums with loss of one tooth. None showed any exophthalmos.

All of the children exhibited roengenographic lesions of skull or bones. The latter were in jaws and vertebrae. In the skull the rarefied areas were generalized or in the parietal bones. Two of the children showed mild hypochromic anemia with the hemoglobin falling to 8.8 gm. and the erythrocytes to 3,000,000. In the remainder, the hemoglobin was from 10 gms. to 13 gms., with 4,500,000 red blood cells. The platelets were always over 185,000, and all bone marrow examinations were hyperplastic. The cholesterol content of the blood was below 200 mg. in only one instance. In all of the others it was over 200 mg. with a maximum of 385 mg.

Three of the children showed polyuria and polydipsia which is still present, although much reduced by treatment. Biopsy of various lesions in all of the children eventually showed foam cells filled with cholesterol droplets surrounded by a zone of fibrosis when the disease had run a year.

Only one child was found with eosinophilic granuloma. This was a solitary lesion of the radius, and was observed in routine examination. There were no symptoms or any enlarged liver, spleen, or lymphadenopathy. The blood and urine were normal. Microscopic examination of material from the area showed a granulomatous process characterized by eosinophils and large mononuclear cells, containing no lipid material. He has been well for the past two years, and has shown no other lesions.

The course of the infantile type, with symptoms beginning under 1 year of age, is progressively fatal. The shortest course of the disease was three months, and the longest 18 months. One of the infants is still alive at 17 months, the first symptoms appearing at 5 months.

In the childhood type in which the first symptoms begin after 1 year of age, all are alive at the present time. One instance of eosinophilic granuloma, first observed at 7 years, has shown no progression and no symptoms after two years.

Our series, therefore, agrees with Wallgren's conception of the disease, that all three types are part of the same disorder, the differences in symptoms and progression being only a matter of degree. In those infants whose initial symptoms began under 1 year of age, three developed skull rarefactions similar to those found in all of the older children, and the histological findings in the older child with eosinophilic granuloma were no different from those found in the younger group.

This is further indicated by the blood picture of the various age groups. In the older children

TESTS	R.D. Age—2 mos. Letterer—Siwe's Type	R.B. Age—3 mos. Letterer—Siwe's Type	K.A. Age—5 mos. Letterer—Siwe's Type	L.G. Age—6 mos. Letterer—Siwe's Type	J.P. Age—10 mos. Letterer—Siwe's, Mixed
Blood RBC	6-8 gr.	4-5.8 gr.	5-12 gr.	6-10 gr.	4.3-8.9 gr.
Blood Hgb.	2-3 million	2.6-3.1	3-3.8	1.5-4.0	1.2-3.2 WBC 9.0-110,000
Platelets	139,000	150,000	200,000	250,000	42,000 138,000
Reticulocytes	9.4-40.2%	1-2%	1-2%	2-2.5%	4-6%
Serum Bilirubin	1.1-1.5 mg.	0.2 mg.	0.2 mg.	0.8-2.5 mg.	0.9 mg.
Bone Marrow	Hypoplastic Normoblastic Hyperplasia	Hypercellular	Hypoplastic	Hypoplastic	Leukemic Hypoplastic
Fecal Urobilinogen	49 mg.	0	0	17.8 mg.	15.0 mg.
Agglutinins: Coombs-direct	Negative	Negative	Negative	Negative	Negative
Agglutinins: Cold	Negative			Negative	
Albumin/ Globulin	3.7/1.5	3.5/1.5	3.5/1.5	4.0/2.0	Normal
Cholesterol	107 mg.	105 mg.	182 mg.	165 mg.	190 mg.
Thymol Turbidity	7.0	2.0	0	2.5-4.0	0
Roentgenograms	Lungs—some hilar markings	Skull-lesions	Skull-defect left temporal. Lungs—infiltration	Skull-defect parietal-temp., Lungs—heavy hilar markings.	Skull-separation sutures. Lungs—infiltration hilum.
Results	Disease—5 mos. Died—7 mos.	Disease—9 mos. Died—11 mos.	Disease—12 mos. Alive—17 mos.	Disease—3 mos. Died—9 mos.	Disease—18 mos. Died—20 mos.

there was only a very slight hypochromic anemia, while in the younger children there was severe anemia with a reduction of blood platelets. We would like to emphasize again that two of the younger group showed evidence of a hemolytic anemia that developed later in the disease.

In one boy, in which the initial symptoms began at 10 months with enlarged liver and spleen and generalized adenopathy, the blood picture was leukemic. The bone marrow was characterized by an increase in nucleated red blood cells and immature monocytes. This picture completely changed to that of Letterer-Siwe's disease but with symptoms also (polyuria) of Hand-Schuller-Christian disease, with the bone marrow showing histocytes and foam cells.

This might indicate that not only are the three types of this condition all a similar process, but that a leukemic form also exists. Silver[7] has reported a similar instance. Dameshek[8] believes that erythroleukemic processes could be considered as part of a group of closely interrelated disorders, and all may be variable manifestations of proliferative activity of the bone marrow cells. The cause may be an undiscovered stimulus which may affect the marrow cells diffusely or irregularly, resulting in various syndromes, either clear-cut or transitional. The relation of these variations is shown in the diagram.

It would appear also that reticuloendotheliosis is increasing. A few years ago only about 50 cases had been reported; now they are not uncommon. Christie[9] has reported a series of 15 of the infantile type in the last 10 years, and our hospital incidence in five years was 1 in

R.R. Age—3 yr. Hand Schüller Christian	B.R. Age—3 yr. Hand Schüller Christian	P.N. Age—3 yr. Hand Schüller Christian	S.M. Age—2 yr. Hand Schüller Christian	P.P. Age—2 yr. Hand Schüller Christian	G.M. Age—8 yr. Eosinophilic Granuloma
9-10 gr. 4.0-4.2	8-10.5 gr. 4.4-4.8	11-13 gr. 4.3-4.5	8.8-10 gr. 4-4.3	8-10 gr. 4.2-4.6	12 gr. 4.8
190,000	185,000	250,000	250,000	240,000	250,000
1-2%	1-4%	1-4%	1-2%	1-2%	2%
0	0	0	0	0	0
Hyperplastic	Hyperplastic	Hyperplastic	Hyperplastic	Hyperplastic	Normal
0	0	0	0	0	0
0	0	0	0	0	0
Normal	Normal	Normal	Normal	Normal	0
228	185 385	290	245	319	175
0	0	0	0	0	0
Skull defects, parietals	Skull defects, parietal-temporal, jaw, vertebra	Skull defects, parietal-temporal	Skull defects, parietal-temporal	Skull defects, multiple areas	Defect radius
Disease—2 yrs. Alive—5 yrs.	Disease—5 yrs. Alive—7 yrs.	Disease—5 yrs. Alive—8 yrs.	Disease—5 yrs. Alive—7 yrs.	Disease—3 yrs. Alive—5 yrs.	Disease—4 yrs. Alive—12 yrs., no other lesions

260. I do not believe this is due to any better diagnostic methods.

In the differential diagnosis, the rash may be confused with eczema, seborrhea, exfoliative dermatitis, or meningococcemia. The hepatosplenomegaly must be distinguised from leukemia, tuberculosis, syphilis, thalassemia major, or portovenous hypertension. Finally, the lung infiltration may be mistaken for histoplasmosis or tuberculosis, and the bone lesion for bone cysts, ostitis fibrosis cystica, multiple myeloma, or metastasis from neuroblastoma.

Diagnosis is best made from histological sections of the skin, lymph nodes, or an accessible bone lesion. The bone marrow is not always reliable; the typical cell contains no vacuoles and is relatively small, not unlike the epitheloid cells in a tubercle. Eosinophils are sometimes increased. In children where the condition has lasted over 12 months, the granuloma will begin to show typical foam cells containing cholesterol and cholesterol esters.

Treatment of the younger age group is unsatisfactory. Adrenocorticosteroids and antifolic acid compounds will make the child more comfortable, but only prolong the eventual outcome. The skin lesions will disappear under X-ray, but will return. Diets low in cholesterol and fats have no particular value. Antibiotics for the intercurrent infections and blood transfusions as needed will give the child considerable relief.

Christie, however, has reported two apparent recoveries with the above regimens. In one of the infants with uncontrollable hemolytic anemia the spleen was removed. While the in-

fant was much improved for a time, the effect was only temporary, the child dying of infection. In the older group the prognosis is much better. The children were much improved with ACTH and other adrenocorticosteroids, and we felt that a cholesterol low diet was helpful. Polydipsia and polyuria were easily controlled with pituitary substances.

CONCLUSIONS

Over a period of five years, 11 children with reticuloendotheliosis were observed, or an incidence of 1 in 260, in the Research and Educational Hospitals. In five, symptoms began under 1 year. Only one is now living. In five, symptoms began after 1 year, and all are living. One child with a solitary bone lesion (eosinophilic granuloma) has had no further increase in these lesions.

The series indicates that all three types are part of the same disorder. The difference is only in the degree or intensity of the disease, which is linked to the age of the child.

Treatment was unsuccessful in the younger age group, although the infants were more comfortable, and their life span was increased by adrenocorticosteroids, corticotropins, antifolic acid compounds, transfusions, and antibiotics. The older age group responded well to the above treatments plus pituitary compounds to control polydiypsia and polyuria.

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Tetanus toxoid

Outbreaks of diphtheria during the past year, while not large, have raised the question of diphtheria immunization not only for children but for adults. Since ordinary diphtheria toxoid is not suitable for children above the age of 10 or 11, much interest has been evinced in the production of a toxoid for adult use. Several pharmaceutical manufacturers are working on the problem and at least one such product is now on the market. It is a combination of diphtheria and tetanus toxoid alum precipitate. The dosage is two injections of 0.5 cc. given intramuscularly four to six weeks between injections. The use of this material on a large scale would have the great advantage of producing active immunity to tetanus as well as increasing the number immune to diphtheria. The last meeting of the House of Delegates of our State Association resolved that the State of Indiana should work diligently toward universal immunization against tetanus. All citizens of the state should be informed concerning the importance of complete and universal immunizations against these two diseases and indeed should be acquainted with the advantages of the use of all standard immunizing agents. *Editorial. Diphtheria Immunization for Adults. J. Indiana M. A. Feb.* 1957.

Urinary Bladder Herniation: Diagnosis and Review of the Literature

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THE surgical repair of external abdominal herniations has long been one of the most common operative procedures performed by the surgeon and general practitioner. The purpose of this paper is to direct attention to the frequency and importance of urinary bladder herniation associated with inguinal and femoral hernias, chiefly those occurring after the third decade of life and with special reference to direct inguinal and femoral hernias. In this group we are likely to find long-standing large hernias, the contents of which often are sliding viscus, a challenge to adequate permanent repair.

INCIDENCE

Actual herniation of the bladder, although not commonplace, is by no means a surgical curiosity. The reported incidence varies from one to 10 per cent of all hernias. In our experience, the latter figure more nearly expresses the correct incidence. The low incidence of some series would seem to be more a failure to recognize the condition rather than its rarity.

	Bladder Herniations	%
Last 100 cases reviewed All ages	10	10
Last 100 cases reviewed Over 40 years of age	11	11

In view of this high incidence, it behooves us who are doing herniorrhaphies to make a diligent search for this bladder complication in every patient over 40, if we are to avoid urinary extravasation.

HISTORICAL

The writings of anatomists and hernialists go back as far as the 1st century A.D. when Celsus stressed the importance of excising the hernial sac and obliterating the peritoneal opening. Galen described indirect inguinal hernia in the 2nd century. Little appeared in the literature on hernia until the 11th century. About this time Albucusis discussed bladder herniation in inguinal hernias and in the following century this condition was again described by Sala. About the 14th century Guy De Chauliac discussed this condition, mentioning the urethral catheter as a diagnostic aid. In 1889 Verdie wrote a constructive dissertation on this subject, and later articles appeared by Percival Pott, John Hunter, and Ashley Cooper.

ETIOLOGY

The important etiological factors in the production of hernia of the bladder are the same as those for any other type of hernia. They can be enumerated under the following headings:

(1) *Congenital predisposition* as had been discussed in many previous publications.

(2) *Bladder pathology,* which would include prolonged overdistention of the bladder due to prostatic or urethral obstructions. There is greatly increased effort of contractility of the bladder early in these conditions, with a later flaccidity and inability to contract. This atony permits a rather large area of bladder in the upper pelvis rather than contracted low in the pelvis as is normally found. This permanent enlargement overlies hernial weaknesses and there is nothing to restrain the bladder as there is in its normal anatomical position.

(3) *Weakness of the abdominal wall.* This refers to enlarged hernial rings and marked weakness over Hesselbach's triangle, leaving no true support for the abdominal viscera. With bladder distention the bladder is one of the first organs to be involved in this herniation.

(4) *Age and Sex.* This disease usually occurs after the third decade and is somewhat more common in men than in women. Eggenberger[1] reported a series of 241 hernias of which 168 were in men and 73 in women. This merely stresses the increased incidence of hernias in the male population in general and probably shows occupational influences.

(5) *Obesity, lipoma, and increase of prevesical fat.* As we know, fat contributes toward the weakness of any organ, especially near a potential space as in hernial predispositions. It is stated that prevesical fat may have a tendency to draw the bladder through a hernial ring due to its attachment to the surrounding tissues; or there may be a lipoma in this area that protrudes through an existing hernial sac and pulls the bladder forward and downward.

(6) *Diverticulum of the bladder.*[2] In these instances the diverticulum of the bladder may have pre-existed and now, due to its location, finds its way into a hernial orifice. But more probably, an overdistended bladder lying over a hernia or a potential hernia eventually protrudes through the ring in a finger-like process due to continuous increased intra-abdominal or intravesical pressure.

(7) *Occupation.* Certainly anyone who has a strenuous occupation is more prone to develop protrusion of a viscus through a weakened inguinal region and this also is true for the bladder.

(8) *Constipation.* This may be stated as a factor in the production of bladder bulging, the same as any straining tends to produce herniation.

(9) *Chronic cough,* which causes increased intra-abdominal pressure.

(10) *Trauma to the abdominal wall* may weaken the inguinal region or may cause sudden increased intra-abdominal pressure and herniation. This is especially true if the bladder is overdistended at the time of injury.

(11 *Old age* may be a factor in weakness of the abdominal wall and the occurrence of large sliding hernias.

(12) *Pregnancy.* Any hernia tends to increase during pregnancy. When the bladder is elevated it is more prone to be overlying a weakened area.

PATHOLOGY

There are many reports of pathological or abnormal locations of the bladder in almost all types of hernias of the lower abdomen. There are rare occasions reported of bladder hernias being obturator, suprapubic, ischiorectal, or protruding directly through the rectus abdominus muscle. However, the type that we are primarily interested in occurs in association with direct or indirect inguinal, or femoral hernias. There are various classifications of the pathological location of the bladder, but that reported by Jaboulay and Villard[3] is more common, and the terminology used is with the relationship of the bladder to the peritoneum. They classify bladder herniations in the following groups:

(1) *Intraperitoneal.* This more commonly represents a diverticulum of the bladder which was protruded into the peritoneal cavity and in turn through the neck of the hernial ring or into the peritoneal lining of the hernia.

(2) *Extraperitoneal.* The bladder, due to its distention, may protrude forward either as a prominence of a localized area of the bladder or as a diverticulum which is formed extraperitoneally and protrudes down through a hernial ring, not necessarily in direct contact with the peritoneum.

(3) *Paraperitoneal.* This is the type most frequently encountered and represents the same pathological process as seen in most sliding hernias, as the neck of the sac is really lined by bladder on the medial side.

The pathology of the bladder in relation to this area has been discussed, but the histological characteristics may have remained quite normal. The bladder wall may be greatly thickened, as in strangulation of the bladder or prostatic or urethral obstruction. It may be thinned to a great extent due to a rather recent herniation or a long thin diverticulum protruding from the bladder. However, no constant findings can be recorded in relation to the wall of the bladder. The content of the herniated bladder is normal urine and may or may not be infected. In a long-standing diverticulum with a narrow neck there may be stagnation of urine and later infection. But in the majority of cases, the content is normal urine.

SYMPTOMS

In our experience there are no signs or symptoms except the finding of an inguinal mass. Some symptoms may be present but I have never found anyone who gave me a clew of the diagnosis preoperatively, except that s u s p i c i o n should be present when you have a large irreducible hernia that has been present for some time. You would expect many more symptoms when you see this complicated condition at the operating table but rarely have there been any urinary

complaints. If positive signs and symptoms are present they usually are:

(1) The presence of a bubonocele that disappears on urination and reappears when the bladder fills.

(2) The two step urination sign, as described by Heinke[5] and Watson.[4] The two step term merely refers to the emptying of the normal urine of the bladder; then, by a little pressure on the bladder or a change of position, the patient may again empty a small amount of urine from the bladder, which has been contained in the hernial sac.

(3) An unusual amount of tenderness over this hernial sac. As we all know, there is normally little tenderness over the hernial sac itself, provided it can be reduced and is not strangulated. Frequently when the bladder is incorporated there is tenderness due to the increased intravesical pressure.

(4) The persistence of a soft, doughy mass in the hernial region, even after reduction of the largest portion of its contents. The remaining small mass is due to bladder wall.

DIAGNOSIS

Diagnosis of this condition rarely is made preoperatively. If there are true diagnostic signs preoperatively, they usually are:

(1) A change in the size or disappearance of the hernial bulge after urination or ability to reduce this bulging after partially emptying the bladder.

(2) Urinary symptoms such as frequency, dysuria, and urgency would usually be present only if the patient had a complicating urinary tract infection.

(3) Urge to urinate after replacement of hernia.

(4) At surgery, (a) If the bladder hernia is associated with an indirect inguinal or femoral type, the red, thick doughy bladder wall will be recognized on opening the sac either as a sliding type and part of the wall or as a diverticulum within the hernial sac or lying completely outside. (b) If bladder herniation is complicating a direct type, it may be pushed back into abdomen. or inverted without ever being recognized.

(5) Frequently the sac is difficult to locate in this area due to prevesical fat. On isolating it, there is a deep red-brown mass and, if it is opened accidentally there is immediate escape of straw colored fluid which can be easily identified as urine. In some instances no sac will be found; instead there will be bulging of bladder wall which is confusing if one is searching for a sac.

(6) The hernia may be large. Any long-standing hernia with a large sac should immediately make one suspicious of the presence of bladder in the wall of the hernial sac.

(7) The hernia may be irreducible or reduce with great difficutly, and bladders have been known to rupture due to a moderate amount of pressure in this area causing extravasation of urine.

This condition is not always recognized at the time of surgery, and one occasionally is forced to accept the diagnosis of bladder herniation with inadvertent incision into it, a few days after the operation. This grave complication with urinary extravasation usually becomes evident about the third day when the patient becomes febrile and has a red indurated wound. At this time one recognizes the fact that the bladder has been opened and immediate repair must be undertaken accompanied by continuous catheter drainage of the bladder.

SURGICAL TREATMENT

The early or simple type of bladder herniation usually associated with the direct inguinal hernia, needs only inversion of the protrusion by use of interrupted Lambert sutures, followed by a classical herniorrhaphy of the surgeon's choice.

A more advanced type of herniation, which will show a definite bulging mass, can be treated either by one or more rows of inverting Lambert sutures or by one or a series of purse string sutures and then by reinforcing the transversalis. The remainder of the repair is left to the preference of the surgeon.

The third type is that in which the bladder exhibits itself as a finger-like process or diverticulum extending into the hernia, and which should not be inverted and returned into the bladder. Instead, it should be amputated after freeing it down to its base or to the wall of the bladder. The bladder wall is closed either by inverting Connell type sutures or by interrupted or continuous catgut sutures through the bladder wall as a submucosal suture, and then reinforced by interrupted nonabsorbable suture, followed by a classical type hernial repair.

After repair of this type of hernia, we must allow for adequate bladder drainage for eight to 12 days to assure complete healing of the bladder wall before straining may be permitted. Therefore, a retention catheter is always placed in the bladder for the first week or more. In most of these large bladder hernias, especially those of the direct inguinal type, we have used the type of repair reported by McVay, which has been satisfactory. In only one instance has it been necessary to use any foreign material such as mesh for reinforcement over this area, as usually there is sufficient fascial support if it is dissected free and an adequate approximation performed. Every operator has his own method of choice for completing the herniorrhaphy.

PROGNOSIS

Due to the varieties of hernias described in this paper, we can see that the prognosis must be somewhat guarded as we usually are dealing with a hernia of long standing and also, bladder hernias usually are associated with rather large hernial defects. Prognosis depends upon two factors, as do all hernial repairs: a good isolation of the sac with high ligation and proper and adequate repair of the transversalis fascia.

We feel that nonabsorbable suture material is important in this repair. Where the bladder has been injured or opened, the use of continuous bladder drainage by urethral catheter for the first several days is mandatory. It is immaterial whether fascial strips are used in this repair or foreign substances, such as tantalum or nylon mesh. In some large hernias these materials may be of benefit. From the series of cases recently reviewed we think the prognosis is favorable as there have been no recurrences, to our knowledge.

SUMMARY

This paper reveals some facts on bladder herniation with special emphasis on incidence, treatment, types, and the complication of failure of its recognition. The occasional hernialist may fail to recognize this complication. In reviewing some of the reported series we find bladder hernias discussed much more frequently by surgeons doing the most herniorrhaphies. This is natural but is rarely mentioned by those doing occasional cases which makes one think that it is frequently overlooked.

We wish to emphasize the frequency of this pathology in association with inguinal and femoral hernias. The frequency varies in different series reported and is usually quoted as 3 to 10 per cent of hernias. As evidenced in our own series, it is commonly found after the fourth decade and the bladder must be very carefully isolated. The previously reported incidence of this pathologic condition is probably low not because of its rarity but because of failure of recognition. In all long-standing hernias, especially large and irreducible ones and those not completely reducible, this bladder complication should be suspected.

Most hernias can be reduced easily unless there is omental attachment either from prolonged incarceration, irritation from wearing a truss, or bladder herniation.

It is well to mention that there is no particular harm in inadvertently opening the bladder, provided it is recognized and the bladder wall immediately repaired, as described under treatment of this condition. It is better to have found the bladder herniation, even though it has been opened, than to miss it entirely. However, failure to recognize the opening into the bladder may be serious resulting in great extravasation of urine and possibly death of the patient.

In spite of all the symptoms described in this paper and with all the diagnostic aids at our hands, it should be stressed that the condition is rarely diagnosed preoperatively, may be missed at operation, and even go unrecognized after opening into the bladder.

In conclusion, we would again like to stress the frequencey of occurrence of this condition, especially in large, long-standing, and irreducible hernias of the older age groups, and the importance of dealing with both the hernial sac and herniation of the bladder to assure an uncomplicated postoperative course and minimal recurrence rate.

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Angiography from the Viewpoint of the Neurological Surgeon

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THE introduction of percutaneous puncture of the carotid artery greatly simplified the procedure of angiography and, on the whole, has greatly diminished the time interval during which X-ray equipment is made unavailable for other procedures—an important matter from the radiologist's point of view. Further, the introduction of percutaneous vertebral angiography, by any one of several techniques which have been devised, adds to the range of usefulness of the method. Sufficient time has now elapsed and sufficient experience has been gained to permit reassessment of angiography; and this subject has engaged the attention of many in the past few years.

From the standpoint of the technique of injection, the methods have become reasonably well standardized though there is much divergence of opinion as to the special merits of particular variants. There are ardent proponents of the use of general anesthesia for the procedure, the chief argument being that the patient who is asleep is better protected from possible untoward anaphylactic reaction. A second argument is that the patient is quieter; for, unless the exposure time is very short, blurring of the image may result from movement by the conscious patient.

The proponents of local anesthesia argue that the hazards of general anesthesia are eliminated and emphasize that it is sometimes possible to detect early in the course of serial injection an adverse reaction to the dye. It is my personal opinion that in skilled hands, the injections are best carried out under local anesthesia.

Operative exposure of the carotid vessels seldom is necessary but may be indicated when it is impossible to needle the vessel in a thick-necked person. There also are instances when, as in carotid artery thrombosis, visualization of the neck vessels may be indicated. It is possible, percutaneously, to puncture the vertebral artery in its course through the transverse processes of the cervical vertebrae in the lower neck, a method carrying with it surprisingly little danger.

A method of reverse cartoid injection has been developed which permits, when distal occlusion is accomplished, escape of the dye backward into the subclavian and upward into the vertebral vessel. Still another variant of the vertebral technique is the injection of the artery at the base of the skull (the method of Maslowski).

The chief fields of usefulness of the method are in the study of aneurysms and vascular malformations and in visualization of the vascular changes associated with neoplasms. Of increasing interest are the studies now being carried out on thrombosis of the carotid and of the intra-

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cranial vessels. In treatment of these lesions, attacks are now being made both upon unplugging the vessels by open exposure of clots and the application of suction to the propagated thrombus, and by use of blood vessel transplants. I have some reservations as to the wisdom of placing an irritating dye in diseased vessels.

The effort to find more satisfactory contrast media is of great importance. Thoratrast®, because of its striking contrast qualities, was very popular initially. Its radioactivity, however, limits its usefulness. The substance is not safe to use percutaneously since extravasation of the dye into the neck has led to considerable reaction. Of even greater importance, however, has been lodgment of the dye in other structures of the body. When injected in large amounts its radioactivity has given rise to malignant growth in the liver. It is now used only rarely.

The most widely used dye has been Diodrast®, in 35% solution. Considerable concern has been expressed over the years about the matter of iodine sensitivity, for sudden death has followed its use and such deaths often have been interpreted as an expression of an anaphylactic reaction. We routinely employ two tests for possible sensitivity: a drop of the dye in the eye and observation thereafter for signs of inflammation; and the injection slowly of a small amount of the dye some hours before angiography. I have no real confidence that either test is of any value; and the second is surely sufficient to cause trouble in the patient subject to anaphylactic reaction.

It is more probable that the deleterious effects of the dye result from the vascular spasm that frequently can be demonstrated following its injection. Blood vessels, as is well known, are sensitive to stimuli of various sorts and may be thrown into severe spasm. It seems established that Diodrast is one of these noxious agents. For this reason a number of investigations have been carried out in various centers seeking to find a better contrast medium. It seems possible that Hypaque® may prove to be the satisfactory medium that has been sought, though it is still too early to judge its full potentialities for trouble.

In order to place the general subject of angiography in a proper frame of reference to the dangers inherent in the handling of ruptured aneurysms, I am quoting, with his permission, from an unpublished paper of John Gillingham. It deals with the cases handled at the Royal Infirmary, Edinburgh, between 1950 and 1956. Of 299 patients admitted to the hospital with spontaneous subarachnoid hemorrhage, 165 were found to have aneurysms and 29 to have arteriovenous malformations. In four instances, unsuspected tumors were discovered; five patients refused investigation, and in 96 no lesion was demonstrated. As Gillingham pointed out, since these cases fall chiefly in the 30 to 55 year age range, one is obviously dealing with an important social problem. The mortality of expectant treatment is somewhat as follows: 15% of cases may die within the first four hours after the onset of bleeding. In the next four weeks an additional 36% may die.

In analyzing the Edinburgh results, Gillingham found that in the first of the six years studied, their results in nine cases treated by various means following the demonstration of an aneurysm by angiography were a mortality of zero and a morbidity that was virtually nil. There then developed an interesting situation and it is on this that I would want to lay particular emphasis. Word got about concerning the excellent results in the handling of aneurysms. Up to that time, cases sent to the Royal Infirmary had been chiefly instances of interval bleeding and had been operated on some three months following the initial bleeding. They then began to receive patients who were in the acute stages of bleeding and these problems were attacked vigorously with early angiography and early operative correction. Immediately they began to find themselves in serious trouble, particularly in handling aneurysms of the anterior communicating artery, where the mortality rose to nearly 100%. This cataclysmic change so altered their figures that, of their first 120 cases, the total mortality in 93 operations was 18.5%. By radical reassessment of their methods of study and of operative attack, this picture has been changed. In the last 15 months, of 45 patients seen with spontaneous subarachnoid hemorrhage, three died without operations shortly after admission to the hospital; 42 were operated upon, of whom only two died, yielding a mortality of 5%. Morbidity likewise has fallen sharply.

Mr. Gillingham has attributed this improvement in results in no small part to a revised

attitude toward angiography. He believes that timing is of the utmost importance. If the patient's clinical condition is poor and it is thought that the hemorrhage itself has been an insult sufficient to produce significant vasospasm, angiography is postponed. When the patient's clinical condition permits, a single A-P view using 6 cc. of Diodrast is made. If there is indication of vasospasm no further dye is used and further angiography is postponed until there is significant improvement in the clinical condition. A second reason he cites for using angiography with care is the fact that an occasional patient reacts with a sharp drop in systemic arterial pressure and this will further embarrass cerebral circulation.

The conclusion of the Edinburgh school is that if the patient's condition is reasonably good, angiography should be carried out at the earliest possible time. Operative interference should then be postponed, unless the patient's condition is optimum, until toward the end of the first week. Delay beyond this time becomes dangerous because of a tendency for secondary hemorrhage to occur in the second and third weeks. However, there are inherent dangers in early attack which decrease somewhat as the first week progresses. These dangers are the technical problems presented by a swollen brain reacting to the hemorrhage, the friability of the sac in the early days after bleeding, and the presumed greater liability to the re-establishment of spasm in the early days following bleeding.

The results of the surgical group in Edinburgh are striking and challenging and I believe they serve as a goal for those of us who see aneurysms in less frequent numbers. There is no more difficult field in neurological surgery today than that of the handling of these special problems.

Another hazard needs to be considered in relation to angiography and that is the matter of interpretation. Here, I believe, is one of the best examples of a field in which co-operation between the radiologists and the neurological surgeons can be rewarding. Angiography, in the last analysis, is an ancillary method of diagnosis and nice judgment is required in balancing the X-ray findings against the clinical picture. The astute radiologist, by detecting blood vessel displacement, by seeing signs of leakage of the dye, or by interpreting evidence of vasospasm, can make available to the clinician invaluable data. He also will be aware of the fact that certain tumors present telltale findings in blood vessel patterns. Other types of space-consuming lesions, such as abscess, also may be detected. The radiologist will be aware of the limitations of the method and recognize clearly that in certain lesions, such as small parasellar tumors, air studies occasionally may demonstrate a lesion that cannot be defined by angiography. Aware, too, of the dangers inherent in the use of dyes which break down the blood-brain barrier, he will help in the search for less noxious media.

Finally, it may be well to point out that the introduction of radioactive isotopes, with subsequent detection by visual or audio techniques of areas of increased uptake of the isotope, eventually may prove a more benign method of localization applicable to the detection of brain tumors.

Neurological Complications in Otolaryngology

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NEUROLOGICAL complications and the symptoms developing from them may be the earliest symptoms of a serious disease process which brings the patient to the physician. In many cases, these symptoms — referable to the ear, nose or throat — will cause the patient to consult the otolaryngologist. Several months ago I treated a patient for hoarseness following a cold and vocal abuse with the usual satisfactory results in such cases with minimal pathologic changes. He, in turn, asked me if I would see a member of his club who had exactly the same symptoms — hoarseness and slight cough. Examination of the second patient, including visualization of the larynx by mirror laryngoscopy, revealed fixation of the left vocal cord — evidence of recurrent nerve paralysis. This neurologic complication immediately suggested the need for further investigation. Chest X-ray showed a density in the left upper lobe and hilar regions and, following workup, exploration revealed an advanced bronchogenic carcinoma. The outstanding symptom was hoarseness, a reflection of a neurological complication — left recurrent nerve involvement by the lung cancer.

Similarly, in otolaryngologic practice we see neurological complications that may develop from trauma to the head and neck, infection, or benign and malignant tumors. Some of these neurological complications may be treated by treatment of the underlying disease process within our own field. Others, extending to or originating in vital intracranial structures, demand the care of the neurosurgeon trained to handle such problems. Most of them, however, present diagnostic clews that can be obtained by any physician who will examine the head and neck carefully and check the function of the cranial nerves. This examination is not difficult and can and should be accomplished during the course of a so-called routine ear, nose, and throat examination. It means checking the fundi, eye movements, pupils, and corneal reflexes. It also means observing the facial movements, the pharyngeal musculature, the tongue and larynx. Motor function of cranial nerves iii, iv, v, vi, vii. ix, x, xi, and xii can be tested grossly fairly rapidly. Some sensory function can likewise be tested during the course of the examination. Abnormal findings can be noted as they are observed. Interpretation of the findings is another matter, and often requires consultation with neurologist or neurosurgeon. But the abnormalities leading to proper consultation and investigation will not be found if such a detailed examination is not done.

In this era of antibiotic therapy, many practitioners feel that serious complications from sinus and ear infections are a thing of the past. It is true that acute mastoiditis is an unusual complication of acute suppurative otitis media. It also is true that we are now seeing many more severe and persistent ear infections that fail to respond to penicillin therapy and then also fail to respond in turn to aureomycin, Achromycin®, Erythromycin®, streptomycin, and Chloromycetin®, to name a few of the drugs used in place of providing adequate drainage of an abscessed ear by proper and timely paracentesis.

Chronic otitis media, with eroding cholesteatoma still is commonly seen in otolaryngologic practice; and neurologic complications follow in the wake of this destructive process within the middle ear and mastoid. Erosion of the bone about the facial nerve with involvement of the nerve may produce the classic picture of unilateral facial paralysis suddenly complicating what appeared to be a benign process of many years' duration. Both patient and physician are now alarmed at this sudden turn of events in a disease process whose only previous manifestation may have been a slight discharge from a tiny attic perforation and a slight hearing loss.

This is only one of the potential neurological complications that may develop. Intracranial extension of infection by erosion into the labyrinth

or middle or posterior cranial fossae may result in acute suppurative labyrinthitis, extradural abscess, or brain abscess with the development of corresponding signs and symptoms of such extension. Tamari and Henner[1] of our staff as well as Snitman[2] and a group from Hines V. A. Hospital recently reported a number of cases of such neurological complications. Many others throughout the country have continued to see these serious infections, despite the availability of antibiotic therapy. Treatment must include not only surgical drainage of the brain abscess but elimination of the bony focus of infection in the mastoid to cure the disease process.

Stuart, O'Brien, and McNally[3] from Montreal recently reviewed the case records of 125 patients having pyogenic abscess of the brain verified at surgery or postmortem examination. Of these, 85, or more than two-thirds, originated as complications of infections near the brain. They were derived from sources of suppuration about the head, especially from infections of the middle ear and paranasal sinuses. They conclude that "infection of the ears and paranasal sinuses is the commonest source of intracranial abscess and otitis media is the most frequent single cause. Further, intracerebellar abscess is almost invariably derived from primary infection in the middle ear. Acute suppurative paranasal sinusitis with osteomyelitis is the second commonest source of intracerebral suppuration."

Fulminating frontal sinus infection following swimming or acute upper respiratory infection may not respond to antibiotic therapy; and if early drainage is not provided, osteomyelitis may develop. In such cases, as with ear infections, extradural abscess or frontal lobe abscess may occur as a serious neurological complication.

Suppurative infectious processes are not the only ones which produce neurological complications of interest and importance to otolaryngologists. Others, the prime example of which is poliomyelitis, may lead to such neurologic involvement that the vital functions of respiration and swallowing are seriously impaired and demand both medical and surgical assistance. Tracheotomy in bulbar poliomyelitis is now accepted as an invaluable aid in the maintenance of the airway and the patent tracheobronchial passages largely through the efforts of Dr. Thomas Galloway of Evanston a number of years ago. Here, a procedure utilized within our field for many years for high respiratory obstruction, has been adapted to the management of the severe neurological involvement occurring during the course of a systemic viral disease.

Trauma as well as infectious disease may produce severe neurological complications. In many cases injury about the head and neck results in neurological disorders of primary interest to neurologist and neurosurgeon. In others, however, symptoms and treatment may fall in the province of otolaryngology. Skull injuries in serious accidents may damage the inner ear, with resulting dizziness and hearing loss. Fractures through the temporal bone may damage the external ear canal, eardrum, inner ear, or facial nerve. Primary treatment is always directed to possible brain injury but follow-up care must include these other areas. Surgical trauma in mastoidectomy may produce facial nerve complications.

Surgical trauma during the course of parotid gland surgery or thyroid surgery may result in neurological complications. In the former, facial nerve paralysis may develop; and in the latter, unilateral or bilateral vocal cord paralysis. Bilateral paralysis of the vocal cords often demands immediate restoration of the airway by tracheotomy. Later, laryngeal surgery may be necessary to restore the airway so that the patient may not require permanent tracheotomy.

Unilateral vocal cord paralysis is of particular interest to the otolaryngologist because it may be produced by any one of many underlying disease processes. It must always be considered a symptom — and the first question should never be "how do we t r e a t it?" but "what is the cause?". Causes include injury to the neck, surgical trauma, or bronchogenic carcinoma, and the diagnostic investigation must be thorough.

Many neurological complications seen within our field are caused by the development and growth of tumors, both benign and malignant. In the neck, neurofibroma or neurofibrosarcoma as well as thyroid carcinoma may involve the recurrent laryngeal nerve and produce hoarseness. Metastatic carcinoma may involve the brachial plexus with symptoms referable to the arm. Recently we saw a patient whose only symptoms were those referable to the arm, and whose primary tumor was a large carcinoma of the

esophagus, suspected first by the neurologist.

Tumors in the middle ear may extend to involve not only the facial nerve but those in the jugular foramen, producing symptoms referable to the throat and larynx. More and more such tumors are being reported arising in the glomus jugularis near the middle ear, first described by Guild in 1941.[4] These tumors are histologically benign but their location deep within the skull makes them potentially malignant as they grow and destroy surrounding structures.

Carcinoma of the nasal cavity, paranasal sinuses, and nasopharynx often lead to extensive neurological complications. Few symptoms exist in the early stages of carcinoma of the nasopharynx. Later, there may be unilateral nasal bleeding, nasal discharge, or partial obstruction. These tumors develop at the base of the skull and, as they extend into the bone in that region, involve the cranial nerves. Pain from involvement of the 5th nerve may be very severe. Later, eye movements may be impaired as iii, iv, and vi are involved. The facial nerve may also be included in extensive tumors. And some, with extension posteriorly along the base of the skull may also destroy ix, x and xi on the side of greatest involvement.

SUMMARY

Within the field of otolaryngology we see many patients whose symptoms result from neurological complications of the primary disease process. Neurological involvement may result from trauma, infection, or tumor. Many of these patients are first seen by the family physician who must be able to recognize such neurological complications. A competent and thorough evaluation of cranial nerve function should be a part of the routine ear, nose and throat examination.

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Prepared childbirth

I would like to re-emphasize the fact that the prepared childbirth program is really nothing more than a concentration of and definition of basic humanitarian and obstetric principles which have been practiced for countless generations. We do not believe that childbirth is painless. We do believe that operative obstetrics should be carried out when indicated. We do believe that the expectant mother should be allowed to participate as much as she desires and as is obstetrically safe in this, one of the great climactic experiences of her life. We hope that a redefinition of these principles will clarify misunderstandings of this program that have been expressed by both laymen and members of the medical profession alike, and we hope that within not too long a time we will be able to provide not only you but ourselves with information that will tell us whether this process is physiologically as well as psychologically valuable. *C. Lee Buxton, M.D. Prepared Childbirth and Rooming-In at Yale. Pennsylvania M. J. Feb.* 1957.

Acute Porphyria

J. W. Fischer, M.D., Chicago

ACUTE porphyria is a rare metabolic disease considered to be an anomaly of porphyrin pigment metabolism.

Although the disease has been known for almost half a century and a considerable literature has accumulated on the subject little mention is made of this disease in medical curricula and as a result few physicians are aware of its existence.

A more general knowledge would no doubt detect more cases and the old axiom "we see only what we know" could well apply to this disorder.

While no attempt will be made here to delve into the detailed biochemistry of the porphyrins, a basic knowledge is essential for a proper understanding of this metabolic fault.

The porphyrins are pigments composed of four pyrrole rings connected by four methane bridges. These pigments are fundamentally related to cellular metabolism and are present in free or bound form in plant and animal life.

The union of a pyrrole group with iron forms the porphyrin called "heme" and this compound uniting with globin gives rise to hemoglobin. Myoglobin, cytochrome, catalase, peroxidase and other respiratory enzymes are examples of other porphyrin-protein combinations.

The porphyrins of major clinical importance are uroporphyrin and coproporphyrin. These names would imply that one is found in the urine and the other in the stool, but both may actually be found in either the urine or stool normally and they are probably derived from ingested plant and animal tissues. Two isomers of each of these porphyrins are found naturally —Type I and Type III. In health only minute quantities of these compounds may be found in the urine and they are not detectable by ordinary means. However, in cases of porphyria there is an excess of uroporphyrin or the colorless chromogen, porphobilinogen, in the urine.

According to recent evidence[1] porphobilinogen is the precursor of uroporphyrin and coproporphyrin. Recently voided urine may have no abnormal color since porphobilinogen is colorless. Waldenstrom[2] believes that two molecules of porphobilinogen may combine in a ring to form uroporphyrin or in a straight chain to form porphobilin. The latter even more than the uroporphyrin is what imparts a red color to the urine. The urine may also be of normal color but may darken when left standing. In general, porphyria is classified as

1. Congenital (porphyria erythropoietica)
2. Acute intermittent (toxic or idiopathic)
3. Mixed or chronic porphyria (cutanea tardive)

Patients with acute porphyria excrete chiefly Type III porphyrin while those who have congenital porphyria excrete predominantly Type I.

The exciting agent of an acute attack is unknown. Drugs have been incriminated such as barbiturates, sulfonamides, nitrobenzol compounds, metals and alcohol.

Pathologic changes have been variable and inconstant. In some of the fatal cases no changes have been observed in the central nervous system or peripheral nerves. In three recent cases described by Schwarz and Moulton[3] there was a diffuse toxic meningopolioencephalomyelitis with involvement of the sympathetic ganglia. Pathologic changes in the liver have been found in some cases although Kark[4] found few patients with this disease who had an abnormal liver profile.

Acute porphyria is in reality a chronic condition characterized by exacerbations and remissions over a period of time ranging from a few months to many years. The disease occurs in families, affects twice as many females as males and is most common between the age of 20 to 40 years. The attack may manifest itself by abdominal or neurological symptoms. Between attacks the patient may be symptomless or suffer from ill defined complaints such as vague ab-

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dominal pain, bizarre pain in the extremities, insomnia, depression and weakness.

The paroxysms of severe abdominal pains are in the nature of colic which may be localized or general. This is frequently accompanied by nausea and vomiting and slight fever. Jaundice may occur. In women, attacks may be associated with menstruation. The pain is difficult to control and often worse at night. Constipation is the rule. Spasms and rebound tenderness are not common. The leukocyte count may be normal or elevated. It is obvious that the condition may mimic appendicitis, biliary or renal colic, intestinal obstruction or pancreatitis. It is, therefore, not surprising that these patients are often operated upon and a "battle scarred" abdomen attests to the unyielding obstinacy of this disease.

The neurologic findings may simulate a wide variety of conditions including encephalitis, poliomyelitis, polyneuritis, Guillain-Barre syndrome, myasthenia gravis and Landry's ascending paralysis. There may be progressive weakness, convulsive seizures, atrophy, coma, and even death from respiratory failure. Involvement of ocular nerves, dysphagia, hoarseness, flaccid quadriplegia, foot drop and wrist drop have been described. The crises may be preceded by many years by undue nervous symptoms so that these patients are often labeled as hysterical or neurotic types.

Mental symptoms may develop at any time in the course of illness. These are frequently characterized as simple emotional states, irritability and fatigue. Confusional, hallucinatory or psychotic behavior may occur.

The cardiovascular system is frequently involved giving rise to hypertension and tachycardia, and electrocardiographic abnormalities.

The mortality rate once neurological symptoms have developed has been estimated as over 75%. Death is due to respiratory failure from bulbar palsy, pneumonia or hepatic insufficiency.

Watson and Schwartz[5] have devised a rapid easy test for urinary porphobilinogen which is believed to be pathognomonic of porphyria. The test depends upon the chloroform insolubility of the porphobilinogen-aldehyde as compared with the solubility of the urobilinogen-aldehyde compound. The simplicity of the test makes it available as an office procedure and obviously the reaction is of most value in the cases in which the freshly voided urine is normal in color.

False positive tests are rare and no positive reaction was found in 1000 patients studied with miscellaneous disorders by Hammond and Welcker.[6]

M. N.—a white woman 26 years of age, single, entered the Garfield Park Hospital on August 6, 1956, complaining of weakness and severe shooting pains in the legs of 48 hour duration. She was of slight build, skin was pigmented (she recently had been vacationing in Florida) and some excess hirsutism was noted although this was not striking.

She was lethargic and answered questions in a perfunctory manner with no desire to sustain a conversation. She would suspend talking every now and then and turn over in bed as if to go to sleep. Temperature on admittance was 100°. Pulse was 110, respiration 20.

On physical examination note was made of moderate weakness of the legs. There were no abnormal reflexes but the patella and ankle reflexes were hypoactive. There was no head drop and no evidence of stiffness of the back.

In view of the high incidence of poliomyelitis at this time in Chicago this diagnosis was strongly suspected in this patient. A spinal tap was performed and revealed normal pressure, absence of cells, Wassermann and colloidal gold were negative. Sugar was 75 mg% and protein 65 mg%. The blood showed hemoglobin 12 grams; red blood count 4,100,000; white blood count 15,800 with a differential of 72% segmented neutrophils, 1% eosinophils, 26% lymphocytes, 1% monocytes. The hematocrit was 41%. Blood Wassermann was negative. Urine was amber colored and showed no abnormalities. Heterophile agglutination was 1:28.

Within the next few days she began to complain bitterly of lower abdominal pain which was colicky and severe and constipation. At times she was nauseated and vomiting occurred. She attributed this pain to the "premenstrual stage" although she stated this was worse than she ever experienced before. On abdominal examination there was no rigidity or rebound tenderness and bowel sounds were normal.

The pain was especially severe at night and adequate doses of narcotics failed to give appreciable relief. Insomnia and restlessness were extremely annoying. Patient was difficult to manage by the nursing and resident staff.

An X-ray of the colon showed dilatation and atonicity of the bowel. Chest, gall bladder and upper G-I films were all negative. Electrocardiogram was within normal limits. Blood chemistry: Sugar 116; BUN 14; Serum protein 6.1; Albumin 3.9; Globulin 2.2; A/G ratio 1:2. Icterus index was 4 units; cephalin flocculation was negative; thymol turbidity was 2.2.

Gradually there was noted an irrational behavior in the patient. There were psychotic episodes of confusion and disorientation. She became uncooperative and drew the sheets over her head when approached. On one occasion she was found standing in bed in the middle of the night with sheets wound around her body, and was unable to recall this situation the next morning. Crying spells with no provocation occurred often.

Occasionally she would wet the bed during the night.

The physical findings remained the same except for the detection of small, shallow, pale scars on the hands which appeared to be residua of previous vesicles.

In view of the combination of abdominal, neurologic and psychiatric elements in this case together with possible photosensitivity and questionable cutaneous lesions the diagnosis of porphyria was suspected and freshly voided urine was examined. The porphobilinogen reaction was characteristically strong and unmistakable. It remained positive throughout the time the patient was in the hospital.

While there is no known treatment for the victim of this disease various drugs were tried such as chloral hydrate, Vitamin B_{12} paraldehyde, ACTH and chlorpromazine in an attempt to bring about relief from pain. She left the hospital completely recovered after one month, but it is believed she had a spontaneous remission rather than benefit from drug therapy.

SUMMARY

The diagnosis of porphyria should be borne in mind in any obscure nervous disturbance or ill defined acute abdominal condition, particularly when they occur concurrently.

Recognition of this disease entity is important so as to avoid needless laparotomy in the "abdominal crisis" type.

Obviously, toxic agents, notably barbiturates and alcohol should be avoided by these patients and those who are photosensitive should avoid exposure to sunlight and ultraviolet radiation.

Examination of recently passed urine is of major importance and can be screened for porphobilinogen by the simple test devised by Watson and Schwartz[5].

Lastly, these patients, like diabetics, should have on their person a written statement concerning their diagnosis so as not to lead the unwary surgeon to perform useless surgery.

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The same old problem

Sometimes the committee was forced to make decisions respecting the conduct of a leading member of the profession. John B. Murphy frequently was the subject of complaint because of the extensive publicity he received. One member was so incensed at the free advertising which always followed Murphy and others that he advocated the repeal of that section of the code of ethics which prohibited advertising. Medical regulations, he charged, ". . . are for the little man to obey . . . the great men will not or cannot obey them." In 1932 Arthur Dean Bevan, a noted surgeon, was sharply censured by the Society for his widely heralded charge that more than 90 per cent of alcoholic prescriptions by doctors during the prohibition period were "bootlegging prescriptions." Morris Fishbein, editor of the Journal of the American Medical Association, was reprimanded a year later for the publication in a lay periodical of an article on the high costs of obstetrical care. The resolutions charged that Fishbein had followed "the irresponsible de Kruif in attacking the medical profession for personal profit." The Society's reaction to the sensational writings of Paul de Kruif has been consistently antagonistic. *Thomas N. Bonner, Medicine in Chicago* 1850-1950.

The Bone in Research

Robert D. Ray, M.D., Head of Department of Orthopaedics

Dr. Max M. Montgomery, Associate Professor of Medicine: In the absence of Doctor Samter who is temporarily in Alaska, I would like to welcome Dr. Robert D. Ray, new Head of our Department of Orthopaedic Surgery, to our Seminar.

Doctor Ray: Thank you, Doctor Montgomery. It is a pleasure to be here. It is said that Virchow regarded bone as a finished product. However, the studies of Hunter, Duhamel, and Belcher in the 1700's and a host of investigators since have emphasized that the skeleton is an extremely active organ from a physiological standpoint. The studies I would like to present this afternoon have been conducted since 1936, and deal with various aspects of bone physiology. These studies include (1) the relation of endocrines, particularly the pituitary and thyroid, to bone growth and maturation, (2) tissue culture and transplantation experiments, (3) the kinetics of bone salt metabolism.

(1) It has been known for many years that removal of the pituitary is followed by cessation of growth; that following the removal of the pituitary there is atrophy of the thyroid; and it has been known for many years that removal of the thyroid results in cessation of growth. But, as Sevringhaus demonstrated, thyroidectomy is followed by an eosinophil hypoplasia of the pituitary. The question thus arises as to the relative role played by the pituitary and the thyroid in bone growth and maturation. To solve this problem, studies were undertaken on rats which were thyroparathyroidectomized the day after birth and then hypophysectomized 21 days later. At the age of 60 days, following the two operations, the operated rats had a body size and body weight of rats approximately 18 to 20 days of age. Roentgenograms and histological sections of the distal end of the humerus revealed that the "bone age" was also 18 days. When the doubly operated rats were treated with pituitary growth hormone, the body weight and body size had increased at 60 days of age to correspond to normal rats of 50 days of age, but roentgenograms and histological sections of the humerus revealed no increase in maturation over the controls (i.e., the "bone age" was 18 days). On the other hand, the doubly operated rats treated with thyroxin, failed to increase significantly in weight or size but their skeletal maturation as estimated from roentgenograms and histological sections of the distal humerus was advanced beyond the chronological age of normal rats. It appears that the processes of growth and maturation of the rat skeleton are controlled by separate hormones and are capable of responding to selective therapy.

(2) One of the problems facing the bone biologist today is that of "induction." It has been postulated that bone contains a substance which is capable of causing the adjacent connective tissue cells to undergo metaplasia into bone forming cells. The theory is based on experiments in which bone treated by brief exposure to freezing or heat was implanted in the anterior chamber of the eye and bone formation ensued. The critical question in such experiments is whether the bone implanted into the anterior chamber was actually dead prior to implantation or whether the new bone formation resulted from survival and proliferation of some of the

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cells of the graft. There are two possible methods for determining viability of bone: 1) the respiratory rate as determined in vitro with Warburg apparatus, and 2) tissue culture studies. Since bone has a relatively low rate of gaseous exchange, it was decided to use tissue cultures to determine whether bone could survive exposure to freezing or boiling. The criteria of viability were 1) fibroblast proliferation, 2) growth of the implant in the tissue culture, 3) change in pH and production of alkaline phosphatase, 4) the histological appearance at termination of culture. The technique for tissue culture was patterned after that of Honor Fell. Using this method, it was found that bone could survive brief exposure to freezing and heat and, in fact, dehydration in glycerol and serum and slow freezing would allow preservation of bone for as long as 90 days at -78° centigrade with growth subsequently in culture. From this, it would appear that the presence of specific "inductor" in bone is still in doubt.

Since it was found that bone could be preserved as a living tissue for long periods of time, it was decided to study the reaction of the host to the graft to see if such preservation could possibly have any practical significance in terms of a bone bank. To study this, transplants of bone to the anterior chamber of the eye were carried out in rats, guinea pigs and rabbits. Both autografts and homografts revealed vascularization of the graft and growth of the superficial cells for periods up to 10 days. After 10 days the autografts continued to grow but the homografts became surrounded by plasma cells, fibroblasts and tissue macrophages and ultimately underwent aseptic necrosis in the majority of instances. Homografts of embryonic bone, however, continued to grow in the anterior chamber of the eye. The homograft response did not appear to be related to blood groups.

Thus, the use of living homografts of bone seemed to offer little advantage over dead homografts because of the reaction of the host to the graft. However, one should not infer that dead bone implants do not have clinical value. In another series of experiments, implants of whole frozen bone, bone deproteinized with ethylene diamine, and bone decalcified with a chelating agent were implanted into trephine defects in the skull. The results revealed that the decalcified implants were more rapidly invaded by vessels and replaced by new bone, a finding incidentally that was not new but was previously reported by Nicholas Senn of Chicago. Senn concluded from his studies that the best substitute for a fresh autogenous bone graft was an implant composed of decalcified bone matrix.

(3) The last series of studies I would like to present relate to bone metabolism as studied with bone seeking radioactive isotopes. Radioactive isotopes have been used, of course, in a variety of ways clinically and experimentally; these can be summarized under three headings:

A. Volume studies from the relationship:

$$\text{concentration} = \frac{\text{amount of isotope}}{\text{volume}}$$

B. Pathway or pattern studies in which the distribution of an isotope through the body is followed.

C. Rate studies.

We are concerned with the latter type of studies this afternoon. If one introduces a bone seeking isotope such as Strontium^{85} into the blood stream in man, there is a rapid fall in the serum activity. This fall in serum activity when plotted on a semi-log graph can be analyzed as a series of four "First Order" reactions, the rate and volume constants of which can be determined. Theoretically, it should be possible to determine whether these constants have physiological significance. In practice, however, this is extremely difficult. As a substitute, one can carry out surface counting if one uses a gamma emitter such as Strontium^{85}. The fall in serum activity may be explained as the result of two different types of processes: (1) "mixing" or "exchange" reactions with various kinetic compartments within the body (a process that is reversible and should ultimately reach equilibrium) and (2) loss from the system either by way of excretion in the urine and feces or by way of "trapping" in a non-exchangeable compartment within the body such as bone (in the same sense that iron incorporated into hemoglobin within the red cell is not available for exchange during the life span of the cell). Strontium^{85} was administered to 5 essentially normal adult males and the serum levels and fecal and urinary excretion were determined and surface counts were carried out at intervals over the bone (patella), muscle (adductor region

of the thigh) and the general body (according to the technique of Huff *et al.*) for intervals up to 14 days. The semi-log plots of the serum values and excretory values were duplicated by means of an electronic analogue computor and a tentative model was constructed for Strontium^{85} metabolism. The results confirmed previous findings with the isotopes of calcium, barium, and phosphorus metabolism (Bauer, Carlsson and Lindquist) which revealed that following administration of a bone seeking radioactive isotope, a small fraction is incorporated into an exchangeable fraction of the bone salt (which thus may be regarded as one of the exchangeable compartments of the body similar to the extra-vascular fluids); another fraction is incorported into a non-exchangeable or "accreted" fraction of the bone salt. From the studies with Sr^{85}, the volume of the skeletal exchangeable fraction was estimated to be equivalent to 32.1 liters of serum, the plasma clearance by bone accretion 4.86 liters per 24 hours, and the excretory clearance 12.0 liters of plasma per 24 hours. The total exchangeable Strontium space was equivalent to 67.4 liters of serum.

Studies of the foregoing type can be adapted to outpatients and they can also be used to analyze local problems of bone pathology such as fractures or tumors. Facilities are being established to continue the foregoing studies which were carried out at the University of Washington School of Medicine, Seattle.

Doctor Montgomery: The studies you have reported represent a new approach to one of the oldest problems of physicians. I believe that you have opened new vistas for most of us and that many of us will ask for your permission to visit your laboratories before long. We are very grateful to you for your outline of a new and challenging field of research.

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The hormone treatment of polyps

The treatment of nasal polyps has become a favored field for the administration of hormones. Polyps are rather mysterious structures that may be of allergic or nonallergic origin. In addition, polyps have a peculiar functional relationship to the lungs that is as yet unexplained. In polyps of any type, however, according to F. L. Lederer, edema is the most conspicuous change. The surgical removal of polyps, the most widely employed form of therapy is actually a desperate measure that usually starts an unending cycle of polypectomies. Topical use of hormones is of little help but systemic administration will shrink polypoid tissue in a majority of patients. As soon as the hormones are withdrawn, polyps recur, but the episodes of bronchial asthma that are precipitated by polypectomies in the elderly patient are sufficiently severe to justify preference for the use of corticosteroids as opposed to surgical treatment whenever possible. *Max Samter, M.D. Use of Hormones in Treatment of Otolaryngologic Disease. J.A.M.A. Feb.* 23, 1957.

Physiologic Consequences of Gastrointestinal Bleeding

Harold Laufman, Ph.D., M.D., Chicago

A previously healthy animal may be bled suddenly to the extent of 30 to 40 per cent of its blood volume and recover without assistance.[1] In man, when more than 30 per cent of the blood volume is lost rapidly, the body is usually unable to repair the loss unaided. Tolerance of blood loss appears to depend upon many factors. Rate of bleeding and extent of bleeding are variables inherent in all instances of hemorrhage. Yet it is clear that the physiologic toll of bleeding is more or less proportional to the pre-existing status of various body mechanisms. As each is called upon to exert its compensatory reaction to bleeding, it either succeeds or fails to respond in accordance with its functional ability. Even after successful response to the exigencies of diminished blood volume, an organ may fail to resume normal function afterward.

Gastrointestinal bleeding appears to result in irreversible shock earlier than does peripheral bleeding of comparable volume. LaVeen[2] et al. have demonstrated experimentally that duodenal bleeding leads to earlier and more profound hypotension and hypoxia of both the hepatic arterial and portal venous blood streams than does peripheral (femoral artery) bleeding. The resultant anoxia of the liver is apparently aggravated further by spastic narrowing of the intrahepatic portal venous tree[3]. The role of hepatic anoxia in irreversible hemorrhagic shock from gastrointestinal bleeding is probably great.

Wiggers[4] was one of the first to recognize that critical bleeding volume varies with an animal's physiologic status, and that certain tolerance factors must be considered in determining chances of survival. These tolerance factors are of particular importance in gastrointestinal hemorrhage in man, often having a greater effect on prognosis than does the extent of the bleeding. The functional state of every vital organ and physiologic mechanism actually has something to do with tolerance to bleeding, and the tolerance factors themselves are highly important in the eventual consequences of hemorrhage. Age itself, and its associated infirmities must be considered, for we know that bleeding is tolerated less well by patients in the older age groups. Further, the chances for spontaneous cessation of hemorrhage become poorer as arteriosclerosis progresses and thereby tends to prevent normal contraction of the bleeding vessel.

Hypotension. The fall in blood pressure accompanying sudden, massive blood loss is largely the result of reduction in circulating fluid. Whether or not the hypoxic liver contributes to the hypotension by liberating more vasodepressor substance [VDM[5]] in the circumstances is not clearly established. If the blood pressure is kept at a low level by repeated or continued bleeding, a state of shock supervenes from which recovery becomes impossible after a time even though transfusion replaces all the blood which was lost. Shock is then said to be irreversible. An accompanying or pertinent phenomenon of this state is the loss of capillary reactivity to stimulation[6]. When effects of massive and repeated small hemorrhages are compared, the total bleeding volume required to reduce pressure to a standard low level or to cause death depends on the rate of bleeding and the intervals between hemorrhages[4]. When blood is lost slowly, for example at weekly intervals, the circulatory problem is no longer one of hemorrhage, but of anemia[7]. Hypotension following hemorrhage can be looked upon as a compensatory mechanism, in the sense that it may actually prevent further bleeding. But this leads to another of the numerous functional

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Part of Symposium on Gastrointestinal Hemorrhage, Illinois State Medical Society, May 18, 1955.

agonies and antagonies of the body — focal vasospasm and consequent pooling of blood.

Tachycardia almost invariably accompanies severe hemorrhage, but is not seen in moderate blood loss or in slow bleeding. The increased heart rate has been attributed to carotid sinus and aortic reflexes initiated by the fall in blood pressure. Other contributing factors may be reduction in blood flow through vessels of the medulla, liberation of adrenalin, and cerebral influences initiated by apprehension. Rapid heart beat also may be considered compensatory up to a certain limit, in that it seems to represent an effort to complete the oxygenation process of the blood more effectively and to distribute it more efficiently. Yet simple increase in cardiac rate in the presence of inadequate diastolic filling does not increase effective cardiac output, nor does it improve the oxygen-carrying capacity of the blood in the presence of massive hemorrhage[1]. Three low blood pressure phases have been described after hemorrhage[8]. The first is sudden vasovagal reaction with bradycardia and vasodilatation, which develops suddenly during or after bleeding. The second is the stage of tachycardia, low right auricular pressure, and low cardiac output. The third takes time to develop and persists over several days. It is associated with increased right auricular pressure and cardiac output. Rapid or excessive transfusion during this phase may result in overloading.

Coronary Insufficiency. A great consequence of these impositions upon the cardiovascular apparatus is the high incidence of acute coronary insufficiency or actual infarction following hemorrhage. Master[9] et al. found in 103 patients with acute hemorrhage, 95 of which bled from the gastrointestinal tract, that 57 per cent showed evidence of coronary insufficiency or actual infarction. The pre-existence of coronary narrowing, even though functionally unrecognized, tends to augment the chances for coronary occlusion when low blood pressure, poor oxygenation of blood, and increased cardiac work are superimposed. Several investigators[10,11], have reported coronary thrombosis precipitated by gastrointestinal hemorrhage even when the coronary vessels were free of disease prior to bleeding.

Peripheral Vascular Effects. Shock levels of blood pressure also may lead to acute insufficiency in peripheral arterial circulation in the presence of pre-existing peripheral vascular disease. In arteriosclerotic limbs with borderline circulation, gangrene has been reported, apparently the result of prolonged hypotension and tissue anoxia from hemorrhage or other causes[12]. Phlebothrombosis not uncommonly follows excessive blood loss[13].

Thermic Effects. Fever occurs in the majority of patients with hematemesis and melena, irrespective of the cause of hemorrhage. It usually appears within 24 hours, lasts a few days to a week or slightly longer, and may reach 103°F. It follows massive or moderately severe hemorrhage more than it does mild hemorrhage. The cause is unknown but is said to result from absorption of blood decomposition products as well as breakdown of endogenous body protein after hemorrhage[14]. Fever accompanies aspiration pneumonia, a not infrequent sequel of hematemesis.

Hematologic Effects. In general, 500 cc. of blood are replaced or otherwise compensated for in an hour or so. However, restoration of the original total number of erythrocytes normally takes about seven weeks[1]. When liver function, nutrition, and recuperative powers are normal, administration of a diet high in meat protein and iron can shorten this time considerably. As a rule, blood clots more rapidly than usual after severe hemorrhage. The relatively high incidence of phlebothrombosis after great blood loss may be related in some degree to this phenomenon[13]. Contributing factors may be the hypotension, slowed circulation, and accelerated clot retraction known to follow blood loss. On the other hand, in rare instances, fibrinolysis is known to occur after severe hemorrhage, after massive blood transfusions, and in other conditions. Circulating blood normally contains a proenzyme called plasminogen[16]. Under the proper influence it is converted to the active enzyme plasmin (fibrinolysin) by continued excessive amounts of circulating prothrombin or by a principle derived from the tissues, known as fibrinokinase. Other enzymes may activate plasminogen, including the bacterial enzymes streptokinase and staphylokinase, as well as trypsin and chloroform. The resulting fibrinolysis may lead to actual afibrinoginemia, and almost uncontrollable bleeding.

Hepatic Effects. The biochemical changes pursuant to cirrhosis of the liver tend to make gastrointestinal hemorrhage somewhat more hazardous and less well tolerated than in the presence of a normally functioning liver. Anemia is almost always present in cirrhosis. The accompanying platelet deficiency, prothrombin deficiency, diminished adrenocortical function, and lowered glomerular filtration rate, among other physiologic aberrations, combine to lower the tolerance of the cirrhotic patient to massive blood loss. Hemoglobin regeneration after hemorrhage is markedly depressed in animals with liver damage or with infection, because of defective protein synthesis and reduced iron absorption[17]. Vitamin K synthesis is not normally accomplished by the diseased liver. Consequently prothrombin levels are lower, and the protective clotting ability of the blood is not available. This deleterious effect on hemorrhage and its control is obvious. Hepatitis not infrequently follows recovery from hematemesis, and in most instances may be related to blood transfusions rather than to the blood loss itself.

Adrenal Effects. Adrenal cortical function is depressed in cirrhosis, Addison's disease, hypopituitarism, and in other conditions. Adrenal cortical insufficiency leads to a fall in plasma volume and in hemoconcentration. In hemorrhagic shock the decreased blood volume is partially compensated for by passage of interstitial fluid into the vascular system, producing hemodilution, in which the relative cell volume and concentration of plasma protein fall[17]. For these and other reasons, the superimposition of hemorrhage on cortical insufficiency is extremely poorly tolerated. A major compensatory reaction to hemorrhage is depressed or lacking in the absence of normal cortical adrenal function. Adrenalectomized animals tolerate hemorrhage and other forms of stress extremely poorly unless supported by cortical substitution therapy[18].

Renal Effects. The kidney participates remarkably in the vasco-constrictive phenomena of shock, and this may result in acute renal insufficiency. This reversible condition is characterized by loss of renal function due to renal ischemia and disseminated areas of tubular degeneration. It is known by many names, such as lower nephron nephrosis, acute renal failure, kidney shut-down, acute tubular necrosis, crush syndrome, hepatorenal syndrome, toxic nephrosis, and acute parenchymatous degeneration. Because the renal lesion is disseminated the term, lower nephron nephrosis, is a poor one. The preexistence of arteriolar nephrosclerosis with the resultant limited renal reserve, is said to predispose to renal insufficiency when prolonged shock, blood transfusion incompatibility, or dehydration occurs. This predisposition is aggravated further by the biochemical alterations seen with gastrointestinal hemorrhage, such as azotemia, hypochloremia, and alkalosis.[21] Renal ischemia is proportionately greater than the reduction in cardiac output, and the glomerular filtration rate and tubular excretory function are markedly reduced. If the patient recovers from the organic tubular damage and from suppression of urine and uremia, normal renal function may not be re-established for weeks or months[20].

Blood Volume usually is diminished in accordance with the severity of the hemorrhage, but because of fluid absorption from the tissues and plasma dilution, it may have regained normal range by the time it is measured.

Azotemia. Following hemorrhage into the gastrointestinal tract, the blood urea is almost constantly raised. The rise in blood urea may be present within two hours after hemorrhage and is generally maximal within 24 hours, and occasionally within 48 hours[22]. If bleeding has ceased, usually there is a sharp drop to normal in the next two or three days. Following repeated hemorrhages, a high level of urea nitrogen persists accordingly[23]. Although azotemia in gastrointestinal bleeding is almost entirely accounted for by the rise in blood urea, the amino acid nitrogen also is slightly raised but creatinine and uric acid levels are normal[24]. The available evidence suggests that the usual moderate rise in blood urea is accounted for mainly by nitrogen absorption "in large amounts from the blood in the bowel at a time when the kidneys are hampered by a diminshed volume-flow of blood"[24] and correspondingly low filtration pressure. In unusually severe hemorrhages catabolism of tissue protein possibly becomes important as a source of nitrogen. When pre-existing renal disease or dehydration and alkalosis due to vomiting are part of the clinical picture, blood urea levels of 200 mg. per cent may result. The degree

of elevation has been shown to have some prognostic significance. According to Schiff[23], a blood urea level of less than 30 mg. per cent is a favorable prognostic sign. When it rises to 50 mg. per cent there is a 33 per cent mortality. An elevation of 70 mg. per cent or more leads to death in two-thirds of the cases, regardless of treatment. As a rule, a blood urea content of over 100 mg. per cent indicates pre-existing kidney disease.

Plasma chloride, bicarbonate and total base levels. Changes in these levels are by no means constant. Chloride levels may be high or normal at the time of maximal azotemia and may diminish during the days following hemorrhage[22].

Serum Iron. Within several hours to a day after acute hemorrhage, the concentration of serum iron begins to decrease and remains low until regeneration of erythrocytes is completed. Regeneration of hemoglobin results in the utilization of available iron. The liberation of iron from tissue depots is slower than the rate of iron utilization by the bone marrow, and this is reflected in decreased concentration of iron in the serum[17].

Urinary Findings. The volume of urinary output is diminished for 24 to 48 hours after hemorrhage, but thereafter forced diuresis occurs due to the excretion of urea (provided so-called kidney shut-down does not ensue). Specific gravity of urine is normal or high, and the urea concentration is good, even after some severe hemorrhages. Urinary chlorides, however, usually are quite low. Occasionally, albumin and casts are found in the urine. Because of the absorption of large amounts of nitrogen from the bowel, nitrogen balance is positive despite catabolism of tissue protein as evidenced by the increased excretion of phosphorus and inorganic sulfur[24].

Wound Healing. It is common knowledge that an inordinately high incidence of wound disruption follows surgery for massive gastrointestinal bleeding. If bleeding has continued for more than 40 hours, replenishment of the original hematologic and chemistry values does not necessarily reflect those of the tissues. The catabolic effect of hemorrhage upon tissue metabolism is not entirely clarified but it is known that depleting conditions are followed by a lag in tissue protein anabolism, not reflected in blood values.

SUMMARY

The consequences of gastrointestinal bleeding depend to a great extent upon associated infirmities incident to the age group or to the individual in which the bleeding occurs. It is against these consequences that the physician and surgeon must measure the calculated risk in their judgment of therapy. In this light, the respect held by the surgeon for the conservatism of his medical colleagues is to be matched by the internist's appreciation of the importance of an aggressive surgical attack upon massive gastrointestinal hemorrhage in certain cases.

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EDITORIALS



The ideal profession

Those of us who have been taught to follow the Hippocratic oath and render medical service day and night may find it difficult to conform to the "1956 requirements" of the ideal physician proposed by P. H. Woutat, M.D., of Grand Forks, N.D. In a speech delivered to the North Central Medical Conference, he said:

"The ideal physician must be of fine and scholarly appearance, with great intellectual capacity, of faultless personal habits, and inspire the confidence of his patients and the respect of all others.

"He must be active in community affairs, taking his full part in Chamber of Commerce and service club functions, serve on and advise municipal and other governmental bodies as called upon, be active in local and state affairs, be a good church worker, and attend church frequently.

"He must be available on short notice for papers to local PTA and church groups, service and business girls' clubs, and all other groups and organizations interested in obtaining reliable information on medical subjects. He must take an active part in the various youth programs of the community.

"He must work on and contribute liberally and cheerfully to fund raising campaigns for new hospitals, YMCA and YWCA, old peoples' homes, and nursing homes; give liberal support to the church and community chest; and help defray the deficit of the local ball club.

"He must be active in his local and state medical societies, attend meetings regularly, and accept officer and committee assignments eagerly and perform his duties quickly and with great tact and diplomacy.

"He must be faithful in attendance at hospital staff meetings, be ready to give carefully prepared scientific papers, serve on hospital committees cheerfully and efficiently, keep his hospital records complete in all details, and be prompt with carefully prepared lectures to student nurses.

"He must be a good family man with a gracious and tactful wife who abhors mink coats and other vulgar extravagances, and must spend lots of time at home with his children.

"But above all he must never fail to give his patients the finest possible medical service, keeping abreast of medical progress by reading, attendance at medieal meetings, and taking frequent postgraduate courses. He must be a tireless worker and improve his public relations by spending adequate time with his patients, answering urgent calls promptly day and night, and by not keeping his patients waiting. This must all be done for what has been vaguely defined as a reasonable fee."

As we all realize, conferences take time and good speeches require hours of organization. Money for contributions to causes, no matter how worthy, does not grow on trees. The ideal doctor described would spread himself too thin

to practice medicine as there are only 24 hours in a day.

Perhaps Dr. Woutat had his tongue in cheek when he made these suggestions but we will endorse them provided he puts an "or" between paragraphs. Some physicians are better suited than others to talk to the laity, the Chamber of Commerce, or PTA meetings. By co-operating in a group we can become "an ideal profession" that will win the respect of others.

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The antibiotic smog

The H-bug is the New Zealand name for the hospital epidemic antibiotic-resistant staphylococcus. In this country, a medicolinguist coined a comparable word — nosocomial — for the same bug. According to Antos[1] the dictionary says this term is obsolete as applied to disease caused or aggravated by hospital life.

The H-bug is not a prevalent threat in the United States even though antibiotics are used by the ton and epidemics of respiratory infections by resistant staphylococci have been reported[2].

Antos quotes an experience of Pickerell's, which appeared in the Lancet of July 14, 1956. A group of British physicians were doing their best to eradicate the H-bug from a children's hospital ". . . where these antibiotic-resistant staphylococci became a problem. Certain strict regulations were enforced. Antibiotics were forcibly held to a minimum, reminiscent of the penicillin rationing of 1943 or thereabouts.

"Infants were handled only by their mothers (to whose organisms the babies had immunity) and each room was scrubbed thoroughly between patients. Antiseptics were restricted to a minimum because of their damage to infant tissues. The effects were not immediate. They had grumblers and physicians who refused to comply.

"But they beat them down eventually. Finally, after several months, the incidence of H-bug began to decline. The reduction was steady until, after one year of this program, this nosocomial scoundrel is again a rarity at this institution."

At the annual symposium on antibiotics held last October in Washington, D.C., there was a plea against the current practice of combining two or more antibiotics to delay the development of resistant organisms. The speakers said that this practice cannot be effective unless the organism is sensitive to both or all the antibiotics used in the combination. They recommended as an alternative the discontinuance of the abuse of the antibiotics available as well as strict observance of the basic principles of asepsis and antisepsis. Hospital staff committees have been established in many institutions to control this menace, and a recent editorial says "Their efforts in lessening the spread from sites of infection to bed clothing, to dust, to nasal passages, and skins of new carriers to new sites of infection by varied steps and routes have met with success."

But the mixtures of antibiotics continue to be used. The penicillin-streptomycin combination has given way to mixtures of the newer cyclines and mycins. The list is difficult to complete because new products are being added constantly. Examples are Oleandomycin, Sigmamycin, penicillin V, Novobiocin, Spiromycin, Ristocetin, Amecetin, and Pen-M.

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Second film in new A.M.A. series on doctor-lawyer relations

The second film in the A.M.A. — American Bar Association series on "Medicine and the Law" will deal with prevention of professional liability action, it was recently announced by Dr. George F. Lull, secretary and general manager of the A.M.A. Titled "The Doctor Defendant", the film will be available for medical society showings beginning July 1.

The new film dramatically presents four case reports of situations which caused legal action against physicians. In reviewing these alleged malpractice cases, the sound film also demonstrates how a professional liability committee functions. The film will be premiered at the A.M.A. convention in New York City on June 5.

This film is a companion film to "The Medical Witness" in the series produced by the Wm. S. Merrell Company, in cooperation with the A.M.A. and the A.B.A. as a service to the medical and legal professions. Medical Societies are urged to arrange advance booking dates for the new film for 1957 and 1958 showings. Informa-

1. Antos, Robert J., M.D.: Mycin-Schmycin. Arizona Med. 14:74-76 (Feb.) 1957.
2. Levin, M. N., M.D.: Staphylococcal Hospital Infections. New England J. Med. 256:155-158 (Jan. 24) 1957.
3. Minnesota Med. 40:263 (April) 1957.

tion relative to obtain either of these films may be procured by writing to the Film Library, American Medical Association, 535 North Dearborn Street, Chicago 10, or to Dr. John B. Chewning, director of professional relations, The Wm. S. Merrell Company, Cincinnati 15, Ohio.

The first film of the series, "The Medical Witness", has been shown many times in various parts of this state at joint meetings of the Medical Societies and the Bar Associations. It was named by the New York Times as one of the best 16 mm. films produced in 1956 and has been selected as one of the five best films on professional education. It is hoped that the new film after it is released July 1, will also be shown before doctor and lawyer groups throughout Illinois.

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A doctor as a citizen

Dr. Robert S. Berghoff has recently retired after serving ten years as a member of the Chicago Board of Education. The Chicago Medical Society passed a resolution commending him for the "fine civic work you have done for the citizens of Chicago". This is another proof that doctors do not live in ivory towers and pay no attention to civic affairs in the community where they reside and conduct their practice.

It is interesting to note that the Chicago Board of Education spends 200 million dollars a year, employs 29,000 people and is responsible for the education of more than 400,000 children. In 1947 Martin H. Kennelly, Mayor of Chicago, appointed Dr. Berghoff as one of the 11 trustees of the Board of Education. The job was for five years and there was no remuneration for the services rendered as a Board member.

It necessitated an all afternoon meeting every second and fourth Wednesday of the month, and a full three day session each year when the budget was considered. He was also required to answer an average of 100 letters each week from taxpayers who were concerned with school problems. At the end of the five year term, he was urged to accept a second five year term, and he did accept it.

For 43 years Bob Berghoff devoted his professional work to cardiology. He taught medicine since 1922 at the Stritch Medical School of Loyola University, holding the rank of clinical professor of medicine. He also served his state medical society over a long period of time as chairman of the scientific service committee, which aided many county societies throughout the state in setting up programs for their meetings, and during this period the records show that he traveled to 61 county societies in Illinois where he appeared on their programs to deliver lectures on cardiology, and in a number of them, to conduct a heart clinic during the session. He was vice president of the Illinois State Medical Society when Dr. George W. Post, the president, died, and he immediately assumed the office of president for the unexpired portion of the term.

The next year he was elected to the office of president-elect, at a time when Everett P. Coleman was the president. This was during World War II, and when the Government urged that the annual meeting be annulled that year, he succeeded Dr. Coleman as president the next year, serving 1946-47.

The Illinois State Medical Society, of which Dr. Berghoff has been a member for many years, can join with the Chicago Medical Society in its statement in a resolution, that his ten years of service on the school board "reflects honor on the medical profession". He still cares for cardiac patients in his office and spends much time at the Stritch School of Medicine. But he maintains his interest in the work of the medical societies with which he is affiliated, and in civic affairs.

We know that Bob Berghoff has at least one hobby outside of his medical work, and anyone wanting him to demonstrate this hobby, should take him to a large lake and give him a powerful outboard motor and see him operate it.

He is indeed to be congratulated by his thousands of medical friends in Illinois and elsewhere, for the fine work done during his ten years of service on the Chicago Board of Education.

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Society president participates in youth fitness conference

Dr. F. Lee Stone, president of the Illinois State Medical Society, represented the Society at the Governor's Conference on Youth Fitness in Robert Allerton Park, Monticello, May 5-7.

The conference considered the integration and promotion of youth fitness programs on a state

level. It was recommended that the governor appoint an Illinois Youth Fitness Advisory Committee made up of representatives of governmental agencies and non-governmental organizations working with youths from the ages of 6 to 21 years.

The Illinois State Medical Society is to be an integral part of this Committee, which it was suggested should be headed by a full-time executive officer to be appointed by the governor and acceptable to the medical and physical education professions.

Among the objectives of the Committee would be the adoption of practical and scientifically sound physical fitness tests, to be used in schools; the consideration of medical or health status of young people before participation in physical fitness testing; sponsorship of a statewide survey of fitness; the promotion of regular physical activities, and the development of more community sports facilities.

Gov. William G. Stratton was one of the speakers. Dr. Harry L. Faulkner, president of the Illinois Academy of Pediatrics, and Dr. John L. Reichert represented the Academy.

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Blue Shield and the medical society

Every doctor has a personal responsibility for the success of his Blue Shield Plan, and a direct opportunity to take part in its control. For the first, basic requisite of any nonprofit prepayment plan that wants to use the name and symbol "Blue Shield" is that the plan be formally and continuously approved by the state and county medical societies in its area of operation.

Another requirement, no less basic, is that a Blue Shield Plan's medical policies and schedules of payment be determined by physicians.

Blue Shield is in fact our own chosen mechanism for making our services more readily available, through prepayment, to our patients.

As such, one would expect the relations between all Blue Shield Plans and their sponsoring medical societies to be as intimate and understanding as between the members of any well run family.

A recent survey conducted jointly by the Public Relations Department of A.M.A. and the Professional Relations staff of Blue Shield Medical Care Plans indicates that relationships between the Plans and their local medical societies in general are excellent, and they have improved most notably in the last few years.

Similar questionnaires sent simultaneously to the Plans and medical societies brought prompt responses from 75% of the Plans and 78% of the societies. Of these respondents, 94% of the Plans and 89% of the medical societies reported good or excellent relations with one another. The interesting fact that in 3 cases the Plans thought their relations with the medical society were excellent while the society reported them to be poor, and in three other cases the contrasting opinions were reversed, which only proves that we are dealing with people.

When this questionnaire probed a little deeper into the specific character and methods of liaison, however, it revealed some sizable areas of weakness and some attractive opportunities for improvement.

For example, only 51% of the responding Plans and 58% of the medical societies reported that they maintain "a specific liaison committee" between them. That some of these committees have not exactly rendered conspicuous service is suggested by the fact that in six cases the Plan and the medical society disagreed as to the very existence of a liaison committee between them. As might be expected, there was a very strong correlation between the areas where liaison committees are operating and the areas where the mutual relations are of the best.

Other specific questions related to jointly sponsored meetings for doctors' office assistants; the inclusion of Blue Shield information in the medical society's orientation program for new members; the setting up of cooperative mechanisms for the use of medical society mediation committees to handle patient complaints; and jointly sponsored indoctrination programs for medical students, interns and residents. In each of these areas of potential cooperation, a majority or a very sizable minority of the respondents reported no action as yet.

If the American doctor needs Blue Shield, it is equally true — if not more so — that Blue Shield needs the American doctor. Without his guidance, Blue Shield might become something quite different from what the profession wants it to be. Without the doctor's support and active participation, there would not even be a Blue Shield.

An Argument for Reconsideration of Our Position on Social Security

WALTER C. BORNEMEIER, M.D., CHICAGO

WHEN the medical profession considers the Social Security program for its membership, a great many pros and cons arise. I shall present arguments in favor of Social Security or Old Age and Survivors Insurance for doctors of medicine.

The reasons can be arranged in two categories. The first group will be called the objective, the next, subjective. Under objective reasons for O.A.S.I. for physicians are of course the benefits derived from the program. The benefit for a person who has paid the maximum for eighteen months is $108.50 per month after age 65. If the doctor continues to work and earns $1,200 annually after 65, he must wait until age 72 to draw his $108.50 per month. After age 72, no matter how much a doctor earns, his benefit will be paid. A man and wife, both over age 65 and 62, earning less than $1,200 per year, draw $162.80 per month. A wife comes in at age 62 and a surviving wife at age 62 gets $81.60 per month. The cost is 3⅜ per cent of the first $4200 of income or about $141.00 per year.

Survivors benefits are further enhanced by payment increases for children under age 18. A surviving wife with two or more children collects $200.00 a month until the children are 18, then the wife can collect no more until she is age 62. An example was given in the article by Coffey and Webster of a husband who died after paying 18 months, having at that time one day old twins. The husband had paid $212.00 and his widow collects $37,000 by the time the twins are 18 and she collects further when she reaches 62. Of course, the same can be done by buying insurance; in some instances this could be improved.

The big argument against retirement benefits is that doctors do not retire. Statistics show that one in seven retires at age 65. This percentage probably will increase. After age 72, there is no limit on earnings while collecting payments. Thirty thousand doctors will become 72 in the next fifteen years. These doctors would pay less than $1,000 in Social Security taxes and become eligible for an average of $14,000 each. Today's aged will receive about fifty times what they pay in O.A.S.I. taxes.

Much has been said about questionable financing, about our children and grandchildren picking up the tab for our benefits. This past year the *income* was 8 billion, *paid out* was 5.7 billion. To date 21 billion has been placed in a trust fund, invested in interest-bearing United States Government securities. The money can be invested only thus. If it could be invested in real estate, soon the government would be everyone's landlord, so government bonds should be a good choice.

Also among the objective benefits are payments in case of disability. If not eligible for rehabilitation, disability payments after age 50 for total and permanent disability is a new feature.

So much for the objective reasons. Let us now consider a few other reasons that should at least suggest that we re-examine our position in regard to O.A.S.I.

Who is in favor of O.A.S.I.?

1. The Congress
2. The President
3. Labor
4. The White Collar Class
5. Teachers—College Professors
6. Dentists
7. Lawyers

Occasionally you may hear a Congressman sound a tirade "for the record," but he probably pays and may even accept the benefits.

Who opposes O.A.S.I.?

The doctors.

What are some of the arguments against O.A.S.I.

It is unprofitable: you have to die or retire to collect. But you must have a fire to collect fire insurance, you have to be disabled to collect disability insurance, you have to lose your life to collect life insurance. Insurance was not designed to be profitable. It was designed for security. We may be able to buy term insurance for survivors benefits and annuities for retirement just as cheaply as O.A.S.I. and we certainly should do so.

No federal project is a bargain. We are probably all opposed to the federal government's doing things that can be done by individuals. But where a project depends on a high percentage of usage in order to be economical, some things work well and require state and federal control. For example, roads wouldn't go far if there was no government program. Schools, if optional at individual level would not be the fine system we have today. Vaccination programs without city, county or state encouragement would probably fail to get the 85 per cent necessary for wiping out a disease.

Can voluntary inclusion of the medical profession in O.A.S.I. be accomplished? The answer is no. If only those who intend to use it are required to pay, the cost must be higher. It is only a bank account if you must put in what you expect to take out. If only the building that is to burn were insured, that building would have to pay the entire cost. That is why the voluntary inclusion will never be permitted, and the question about voluntary inclusion in the referendum should be omitted.

The Old Age and Survivors Insurance Act has been in force for 20 years and covers 87 per cent of Americans. If we have objected and are still objecting to inclusion, in order to set an example, we are getting nowhere. If we are objecting because we believe the scheme is unsound, look at the record of 21 *billion in reserve.* If we object because we feel we can handle our own retirement programs and our own survivors benefits, then I think our reasoning has merit. But from my observation this program is as cheap, as sound, as inclusive as a private program and it would be easy to be included. I think it is time to reconsider our position.

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CORRESPONDENCE



Clinics for crippled children listed for July

Twenty three clinics for Illinois' physically handicapped children have been scheduled for July by the University of Illinois, Division of Services for Crippled Children. The Division will count 18 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing service. There will be 3 special clinics for children with cardiac conditions, 1 for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The July clinics are:

July 3 — Hinsdale, Hinsdale Sanitarium

July 9 — East St. Louis, St. Mary's Hospital

July 9 — Peoria, Children's Hospital, (St. Francis)

July 10 — Joliet, Will County T. B. Sanitarium

July 11 — Cairo, Public Health Building

July 11 — Springfield, St. John's Hospital

July 11 — Sterling, High School Field House

July 12 — Chicago Heights (Cardiac), St. James Hospital

July 16 — Alton, Memorial Hospital

July 16 — Danville, Lake View Hospital

July 17 — Elmhurst (Cardiac), Memorial Hospital of DuPage Co.

July 17 — Evergreen Park, Little Company of Mary Hospital

July 17 — Springfield (Cerebral Palsy), Memorial Hospital

July 18 — Flora, Clay County Hospital

July 18 — Rockford, Rockford Memorial Hospital

July 23 — Peoria, Children's Hospital (St. Francis)

July 23 — Quincy, St. Mary's Hospital

July 24 — Aurora, Copley Memorial Hospital

July 25 — Decatur, Decatur-Macon County Hospital

July 25 — Mt. Vernon, Masonic Temple

July 26 — Chicago Heights (Cardiac), St. James Hospital

July 30 — Effingham (Rheumatic Fever), St. Anthony Hospital

July 31 — Carrollton, Carrollton Grade School

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American Board of Obstetrics and Gynecology

Applications for certification (American

Board of Obstetrics and Gynecology), new and reopened, for the 1958 Part I Examinations are now being accepted. All candidates are urged to make such application at the earliest possible date. Deadline date for receipt of applications is September 1, 1957. No applications can be accepted after that date.

Candidates for admission to the Examinations are required to submit with their application, a typewritten list of all patients admitted to the hospitals where they practice, for the year preceding their application, or the year prior to their request for reopening of their application. This information is to be attested to by the Record Librarian of the hospital or hospitals where the patients are admitted and submitted on paper 8½ x 11". Necessary detail to be contained in the list of admissions is outlined in the Bulletin and must be followed closely.

Current Bulletins outlining present requirements may be obtained by writing to the Secretary's office.

Robert L. Faulkner, M.D.
American Board of Obstetrics and Gynecology
2105 Adelbert Road
Cleveland 6, Ohio

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Course in postgraduate gastroenterology

The American College of Gastroenterology announces that its annual course in postgraduate gastroenterology will be given at the Somerset in Boston, October 24-26.

The course will again be under the direction and co-chairmanship of Dr. Owen H. Wangensteen, Professor of Surgery of the University of Minnesota Medical School, who will serve as surgical co-ordinator and Dr. I. Snapper, Director of Medical Education, Beth-El Hospital, Brooklyn, N. Y., who will serve as medical co-ordinator. Drs. Wangensteen and Snapper will be assisted by a distinguished faculty selected from the medical schools in the Boston area.

They will discuss advances in diagnosis and treatment of gastrointestinal diseases and diseases of the mouth, esophagus, stomach, pancreas, spleen, liver and gallbladder, colon and rectum, with special studies of radiology and gastroscopy.

For further information and enrollment write to the American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

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Awards in obstetrics and gynecology

The Division of Obstetrics and Gynecology of the United States Section, International College of Surgeons, announced that two awards will be made for the best manuscripts not exceeding 5,000 words submitted by December 1, 1957. The first prize will be $500 and the second $300.

Contestants must hold the degree of Doctor of Medicine from an accredited college of medicine, and (1) be interns, residents or graduate students in obstetrics and gynecology, or (2) be teachers of obstetrics and gynecology. Fellows of the College are not eligible.

The two successful candidates will be asked to participate in the scientific program of the Division of Obstetrics and Gynecology at the 1958 annual congress of the United States and Canadian Sections, International College of Surgeons.

Details of the contest and the forms in which the manuscript must be submitted may be obtained by writing Dr. Harvey A. Gollin, secretary of the Committee on Prizes, 55 East Washington Street, Chicago 2, Ill.

"The purpose of this contest is to advance the art and science of obstetrics and gynecology, in accord with the principles of the International College of Surgeons and with the aims of the branches of surgery," Dr. Raymond J. Pieri of Syracuse, N. Y., chairman of the Committee on Prizes, said.

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THE P. R. PAGE



Edward A. Uzemack, Director of Public Relations

"When one's all right, he's prone to spite
The doctor's peaceful mission;
But when he's sick, it's loud and quick
He bawls for a physician."
—Eugene Field

WHEN the PR Page made its initial appearance in the October, 1953 issue of The Journal, it was described by the editor as a "bulletin board" for the Committee on Medical Service and Public Relations.

It was explained that the page was "generally intended to serve for the exchange of ideas, (and) reports of praiseworthy public relations work by individuals and county societies." Individual members and county societies were invited to submit appropriate material for the page.

The appeal must have been effective. A random sampling of earlier PR Pages shows a fair amount of space devoted to PR news from the various county societies. But in more recent times the contributions have dwindled to virtually nothing.

At the beginning of this year we printed another invitation to county societies to make of this page an idea exchange. Up until this writing there has not been a single item submitted by any one of the 93 county medical societies. It is possible, of course, to pick up some items from the respective county society bulletins, but the editor feels that direct communication of PR news from the societies would make this a more interesting page.

Correspondence from county society legislative and/or public relations chairmen is especially desired.

If you want to beat your own public relations drum, this is the place to do it. If you have a complaint to make, ditto. If you have questions to ask, fire away — we may have the answers. But whatever you do, please don't sit on your pen. This page is provided for your use; be our guest.

Quote Unquote—

Edward L. Bernays, pioneer in the development of public relations as a profession:

"We are enmeshed with our world through a two-way process. Publics we come into personal contact with — friends, customers, purveyors — affect our attitudes and actions; and publics we never meet affect us through symbols — words and pictures in newspapers, books, magazines, radio, television, motion pictures, lecture platforms, and other communications media. Through this process we come to understand or misunderstand the world around us. And through it we are understood or misunderstood. Since we are dependent on others and want to be understood, it is important that our conduct,

attitudes, and expressions be guided by a consciousness of our public relations."

Adams County PR meeting—

Dr. Theodore R. Van Dellen, health editor of the *Chicago Tribune* and associate editor of the *Illinois Medical Journal,* talked on "Newspaper Medicine" at the recent annual Medical Public Relations Meeting of the Adams County Medical Society in Quincy.

Sponsored by the society's Public Relations Committee, the meeting was open to physicians, dentists, pharmacists, nurses, medical auxiliary members, public health personnel, medical technicians, medical and dental secretaries and assistants of the Quincy tri-state area.

In addition to his talk, Dr. Van Dellen was interviewed on a Quincy TV Station KHQA.

Oblinger, the Author—

Our associate counsel, Walter L. Oblinger, dusted off another of his many talents and displayed it in a recent issue of *Police,* a journal devoted to the professional interests of all law enforcement personnel. He contributed to the publication a treatise on "The Police Officer As A Witness."

A former agent and police instructor for the Federal Bureau of Investigation, Mr. Oblinger did a thorough job of explaining to his readers how to prepare for a courtroom appearance and how to conduct oneself on the witness stand. The editor of this page was particularly intrigued by the following passage, since it is, in a manner of speaking, sound public relations advice:

"Do not wear firearms in the courtroom. The proper thing to do is to remove your holster and gun and hand them to the bailiff or clerk of court. This shows that you consider yourself amenable to and subservient to the law and to this court and jury who are here to administer justice according to law. You may create the impression by not removing your firearms that you consider yourself above the law and in contempt of it."

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Strokes and dollars

In 1952, 170,000 persons died of vascular diseases affecting the cerebrovascular system — three times the number of deaths due to tuberculosis and diabetes combined. Seventy-three per cent of these deaths occurred in persons 65 or older. But looking at it another way, 27 per cent occurred in the highly productive years under 65, i. e. 44,000 deaths from cerebrovascular diseases in 1952 were in the working age group 24-65. If these people had lived even an additional one healthy year they would have earned approximately 151 million dollars and paid the federal government 18½ million dollars in taxes. The cost of 60,000 victims of cerebrovascular diseases in state mental hospitals was 46½ million in 1952; the average length of stay of these patients was four years. It is estimated that in 1955 there were 1,800,000 victims of cerebrovascular disease in the U.S.A. *Charles A. L. Stephens, Jr., M.D. Cerebrovascular Diseases. Arizona Med. July* 1956.

AT THE EDITOR'S DESK



GEVRABON on-the-rocks is Lederle's rival to the dry martini. It is a sherry flavored, appetite stimulating tonic containing the vitamin B complex and many minerals. Its 18 per cent alcohol content will raise a scientific eyebrow or two but remember that Duffy's malt, Lydia Pinkham, and Hadacol did very well on this ingredient alone.

According to a news release from the National Cylinder Gas Company, we now have a stockpile of oxygen that could keep every American going for 71 minutes. Ten years ago there was only a few minutes' supply. In 1956, hospital consumption of oxygen rose to more than 2 billion cubic feet. Forty years ago, medically pure oxygen still was in the experimental stage. The Howard Johnson restaurants on the Pennsylvania Turnpike are giving tired motorists a lift by dispensing this gas via the oxymeter. It is said to relieve fatigue but the modus operandi is beyond the ken of your editors.

The practice of medicine is becoming more complicated as we tangle with the total man. Dr. Francis D. Murphy, of Milwaukee, recommends that the medical management of a patient with heart disease "must continue after convalescence until the patient returns to his maximum physical, mental, emotional, social, vocational, and economic usefulness."

Patients at the Tomah, Wis., VA Hospital are lucky. They are getting ready for the fishing season by making plugs and tying flies. From May to September these fishermen are transported by bus three times a week to nearby lakes for morning and afternoon fishing parties.

Medical Economics reported that the retirement plan dreamed up by Costa Rican physicians struck a snag. They decided to charge detail men 75c a call and put the proceeds into a retirement fund for members. So far, the pharmaceutical houses have refused to co-operate.

Recent studies indicate that the new mustard derivative, ThioTepa, is one of the best all around drugs for treating leukemia and certain cancers. The product cannot be regarded as a cure but it offers promise as an adjunct to cancer therapy.

Furacin ointment (Eaton) is reported in a news release as effective in crypitis.

A new form of estrogen may have many uses in medicine and agriculture. It is cheaper than the older diethylstilbestrol, and a single dose provides estrogen activity for one year in rats. The new synthetic may be of value in controlling prostatic cancer and in fattening beef cattle and tenderizing chickens.

Upjohn has a new orally effective androgenic-anabolic agent — Halotestin. It is said to be five times more potent than methyltestosterone and is indicated in the treatment of eunuchs,

protein depletion, and testicular hypofunction. The androgen may be useful also in controlling uterine bleeding and menopausal symptoms and as palliative therapy in inoperable breast cancer.

Orphenadrine (Ricker) proved successful in alleviating symptoms of parkinsonism in 55.7 per cent of a group of patients.

From Austria comes a report on Rastinon, the latest oral antidiabetic drug.

My secretary comments on the wishbone type of pessary for contraception: Does wishing make it so?

Obesity will be the responsibility of the cook hereafter. The portly need not deny themselves at the table because the low fat meals served will have so few calories they can eat like starving Armenians. A skilled cook, according to Drs. Eugene A. Stead, Jr. and James V. Warren, should be able to concoct tasty meals that no one will suspect of having a low fat content. What else could these Duke University professors say, since the book they are plugging — "Low Fat Cookery" — was authored by their wives.

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Postileostomy

Of 101 ileostomy patients followed, 92 are at full work, seven being convalescent. The two patients doing no work are nearly blind following iritis, one having arthritis in addition. Five patients do not regard the ileostomy as satisfactory, though they do not go so far as to state that it is unsatisfactory, nor are they prevented from following full employment. Eleven patients who consider the ileostomy satisfactory suffer slight or intermittent excoriation. Most patients are able to follow pastimes of their choice such as swimming, dancing, and tennis; old-time dancing is becoming popular. The limitation of activity experienced by 34 patients is due to discomfort on stretching or bending, and sometimes when lifting heavy weights; seven others are still convalescent. Approximately half the patients restrict their diets, most because fruit skins or pips form an indigestible bolus which causes colic as it reaches the indistensible ileostomy stoma. Some find that fruit juices, green vegetables, or salads cause the motions to become fluid; others avoid a large meal in the evening since this may so fill the adherent bag during the night as to require its evacuation. Six patients are dieting in order to reduce weight which has increased embarrassingly. The results remain satisfactory in those treated five years or more ago, five of whom had an ileostomy for 10 years or longer. *B. N. Brooke, M.D. Outcome of Surgery for Ulcerative Colitis. Lancet, Sept.* 15, 1956.

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World peace cannot be attained until we build peace into the hearts and minds of men. Since physicians are the most intimately acquainted with the physical and mental needs of their patients, they are the most logical engineers for this great moral construction project. If we, more than a half million physicians, assume this task on an individual, personal basis, we may yet succeed where soldiers, statesmen and politians have previously failed. Gunnar Gundersen, M.D., World Med. J., May, 1956.

NEWS of the STATE



ADAMS

Personal.—Drs. Gene J. Ahern and Ladislav Stefan have been elected into membership of the Adams County Medical Society.

COOK

Funds for Medical Scholarships.—A share of the trust estate of the late Victor S. Yarros, LaJolla, Calif., has been accepted by the University of Illinois. Mr. Yarros was the husband of the late Dr. Rachelle S. Yarros, a former member of the school's faculty who retired in 1939. In 1948 Mr. Yarros gave $1,000 to the university to support a scholarship memorial to his wife, known as the Rachelle S. Yarros Scholarship Fund. Since 1949, when a trust was created, yearly contributions of $300 have been received. When the Yarros estate is dissolved it is estimated the university will receive between $30,000 and $40,000. Funds now held by the university and funds to be received will be used for scholarships for deserving and needy students in the college of medicine. Sums will be given annually in varying amounts, but not more than $500 will be awarded to any one student in one year.

New Officers:—At the annual meeting of the Chicago Laryngological and Otological Society, April 1, 1957 the following officers were elected for the year 1957-1958: President—Stanton A. Friedberg, M.D., 122 S. Michigan Ave., Chicago 3, Illinois. Vice-President—Maurice Snitman, M.D., 408 S. 5th Ave., Maywood, Illinois. Secretary-Treasurer—Fletcher Austin, M.D., 700 N. Michigan Ave., Chicago 11, Illinois.

Personal.—Dr. Lowell T. Coggeshall has been elected a member of the American Philosophical Society.—Dr. Joseph K. Narat, senior surgeon, St. Elizabeth's Hospital, has returned from a trip through Yugoslavia, Greece and Turkey where he addressed the medical societies in various cities on "Recent Advances of American Surgery, under the auspices of the Department of State, Professional Activities Division, International Education Exchange Service.

Philip Thorek Honored.—The first prize for the best foreign medical-surgical motion picture has been awarded to Dr. Philip Thorek by La Presse Medicale of Paris. Dr. Thorek received the honor for his color film on "Atresia of the Esophagus with Tracheo-esophageal Fistula," one of numerous entries from many parts of the world in the sixth annual contest sponsored by La Presse Medicale. Dr. Thorek is professor of surgery at the Cook County Graduate School of Medicine and associate professor of clinical surgery at the University of Illinois College of Medicine.

Dr. Zimmerman Named to New Post.—Dr. Hyman J. Zimmerman has been appointed full-time professor and chairman of the department of medicine at Chicago Medical School and director of medical education and the department of medicine at Mount Sinai Hospital. At the medical school, Dr. Zimmerman takes over the position vacated by Dr. Harry J. Isaacs, who has headed the division of internal medicine since 1932. Dr. Isaacs voluntarily relinquished this position to make way for a full-time person who could devote his entire time to department administration and improvement of the medical curriculum. Dr. Zimmerman, whose apment becomes effective August 1, is currently associate professor of medicine at the University of Illinois College of Medicine and head of medicine at the West Side Veterans' Administration Hospital.

Ricketts Medal Goes to Dr. Salk.—The 1956 Howard Taylor Ricketts gold medal of the University of Chicago School of Medicine was presented to Dr. Jonas E. Salk, Pittsburgh, May 17, for his achievement in supervising development of the anti-polio vaccine bearing his name. Dr. Lowell T.

Coggeshall, dean of the university's Division of Biological Sciences, made the presentation in ceremonies at Billings Hospital, when Dr. Salk delivered the annual Ricketts prize lecture. The prize, which also carries a $200 cash award, is considered as one of the most distinguished in American medicine. It was established in 1949 by Dr. Ricketts' late widow to commemorate her husband, a University of Chicago physician, who died May 3, 1910, of typhus in Mexico, after demonstrating that Rocky Mountain spotted fever is caused by the bite of the wood tick carrying minute organisms, named rickettsia in his honor.

Apartment Building for Interns and Residents.—The University of Chicago announced recently that it had received a loan of $850,000 from the Communities Facilities administration to construct an apartment building for interns and residents in its medical facilities. The building, which will cost $1,100,000, will be six stories in height and will contain 80 apartments, according to the Chicago Tribune. Construction is expected to begin in the fall. There will be five two-bed room apartments and a number of one room and kitchenette units. The Communities Facilities administration is a part of the federal housing and home finance agency.

New Head of Child Guidance Clinic.—Dr. Jerome J. Schulman has been appointed director of the child guidance clinic at Children's Memorial Hospital, succeeding Dr. Henry H. Fineberg who resigned to return to private practice. Dr. Schulman, whose appointment is effective July 1, is assistant resident in psychiatry at Johns Hopkins Hospital, Baltimore.

HENRY

Society News.—On May 8, Dr. Loring S. Helfrich, Moline, addressed the Henry County Medical Society in Kewanee on "Pitfalls of Gallbladder Surgery."

KNOX

Fifty Year Club Member.—Dr. M. S. Griffith, Galesburg, was inducted into the Fifty Year Club of the Illinois State Medical Society at a recent meeting of the Knox County Medical Society. Presentation of the certificate and emblem significant of the honor was made by Dr. Charles P. Blair, Monmouth, Councilor of the Fourth District. A graduate of the University of Cincinnati School of Medicine, Dr. Griffith has practiced in Galesburg since 1921. Two other Galesburg physicians, Drs. E. N. Nash and Ben D. Baird, are also members of the Fifty Year Club.

VERMILION

Society News.—At the May 7 meeting of the Vermilion County Medical Society in Danville, Dr. James G. Miller, Ann Arbor, spoke on "The Role of a General Behavior Theory in Mental Health Research." Dr. Miller is chief of the Mental Health Research Institute at University Hospital, University of Michigan.

Personal.—Dr. Alfonso Baquero has been accepted into membership of the Vermilion County Medical Society.

SANGAMON

Society News.—Dr. Ralph Emerson Duncan, medical director, Benjamin Burroughs Ralph Foundation for Medical Research, Kansas City, Mo., addressed the May 2 meeting of the Sangamon County Medical Society in Springfield on "Sobriety Corners."

GENERAL

Citation for Assistance in State Health Program.—Dr. Francis J. Braceland, Hartford, Conn., president of the American Psychiatric Association, was recently presented with a citation for his work nationally in the mental health field and his assistance in the Illinois mental health program. Governor Stratton awarded the citation.

DEATHS

Henry W. Abelmann*, Chicago, who graduated at Rush Medical College in 1904, died April 11, aged 76. Injuries in an automobile accident had forced him to give up his medical practice some years ago.

Matthew W. Brucker*, Oak Park, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1906, died April 23, aged 75. He was formerly instructor of eye, ear, nose and throat at Loyola University School of Medicine.

Henry Albert Cables*, East St. Louis, who graduated at St. Louis University School of Medicine in 1903, died February 13, aged 87.

Howard W. Champlin*, Chicago, who graduated at the University of Illinois College of Medicine in 1920, died April 9, aged 73. He was a senior staff member at Ravenswood Hospital.

Leo M. Czaja*, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1911, died May 8, aged 67. He was formerly general superintendent of the Municipal Tuberculosis Sanitarium.

William C. Doepp*, Blue Island, who graduated at Rush Medical College in 1925, died April 30, aged 58. He was an associate surgeon for the Illinois Central Railroad.

Horace B. Dunn*, Spring Valley, who graduated at Bennett Medical College in 1906, died February 25, aged 79.

William H. Garrison*, White Hall, who graduated at Missouri Medical College in 1897, died March 15, aged 88.

Ralph C. Goode*, Chicago, who graduated at Rush Medical College in 1927, died April 21, aged 65. He was medical director of Chicago Teachers

*Indicates member of the Illinois State Medical Society.

College and a member of the staff of the Jackson Park Hospital.

John E. Graf*, retired, Morton Grove, who graduated at Kansas Medical College in 1905, died April 11, aged 83.

Charles H. Hibbe*, Chicago, who graduated at Chicago College of Medicine and Surgery in 1917, died May 2, aged 68.

Adelle Robb Nichol Hobart, retired, Roseville, who graduated at the Woman's Medical College, Chicago, in 1890, died February 11, aged 94. She had practiced medicine in Monmouth and was a member of the staff of the Monmouth Hospital.

Lester A. Kitzman*, Chicago, who graduated at Northwestern University Medical School in 1949, died April 23, aged 57. He was assistant to the chief surgeon of the New York Central Railroad.

Homer L. Lauder*, Champaign, who graduated at the University of Illinois College of Medicine in 1934, died April 12, aged 56.

Joseph Michael Leonard*, Chicago, who graduated at Loyola University School of Medicine in 1925, died February 11, aged 59, of acute pulmonary edema and arteriosclerotic heart disease. He was a member and past-president of the staff of Mercy Hospital.

Hans W. Nilssen*, Chicago, who graduated at the Chicago Medical School in 1923, died April 24, aged 76. He was a member of the staff of the Norwegian American Hospital.

Warren E. Pugh*, Chicago, retired infantry colonel, who graduated at Loyola University School of Medicine in 1929, died April 22, aged 64. He served in both World Wars and was awarded the Croix de Guerre and the Legion of Merit by the French government.

Herman Armand Renz*, Chicago, who graduated at Hessische Ludwigs-Universität Medizinische Fakultät, Giessen, Hesse, Germany, in 1907, died February 15, aged 76, of carcinoma of the lung.

Ralph S. Sabine*, Murphysboro, who graduated at St. Louis University School of Medicine in 1908, died April 6, aged 76.

Reinhold C. Schlueter*, Chicago, who graduated at Northwestern University Medical School in 1910, died April 23, aged 73. He had been a member of the staff of the Evangelical Hospital for 43 years.

Henry C. Scholer*, Monmouth, who graduated at the University of Kansas School of Medicine in 1920, died April 23, aged 66.

Orie F. Shulian*, retired, Quincy, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1911, died March 11, aged 74.

Chester J. Sobierajski*, Chicago, who graduated at the Chicago Medical School in 1930, died May 2, aged 50. He was a staff member of St. Mary's Hospital.

Vito A. D. Taglia*, Oak Park, who graduated at Rush Medical College in 1920, died May 3, aged 60.

Elsie M. Tichy*, Chicago, who graduated at Loyola University School of Medicine in 1937, died April 17, aged 45.

*Indicates member of the Illinois State Medical Society.

Clearing house for tranquilizers

At a recent joint meeting of the American Psychiatric Association and the National Research Council of the National Institute of Mental Health, it was proposed that the new Pharmacology Research Center in the National Institute of Mental Health confer with drug firms and research workers in all fields to develop a minimum safety and effectiveness standard for all these medications. It also has been proposed that this center set up an information clearinghouse to keep physicians, research workers, and drug firms fully abreast of the developments in the tranquilizers and other fields. *Baldwin L. Keyes, M.D. Ataraxic Drugs. Pennsylvania M. J. Feb.* 1957.

Danger of salt

Heat exhaustion and heat cramps probably were due to strain of extra effort in persons chronically short of water. At one time, salt deficiency was thought to be the major factor but he believed that water debt in people who consistently drank too little water was the predisposing cause. When it was hot, extracellular fluid was lost first. About two liters could be spared before the intracellular water was affected. The loss of much extracellular water made a person susceptible to heat exhaustion while depletion of intracellular water was dangerous. The role of salt was complex. In the state of water debt, if water were taken but no salt, intracellular fluid could be maintained and any deficit would fall on extracellular fluid. If salt were taken, particularly in the absence of enough water, intracellular fluid volume fell and extracellular fluid volume was maintained at the expense of intracellular fluid. Intracellular dehydration led to collapse. Treatment consisted in giving plenty of water and a controlled supply of salt; excess of salt would deplete the intracellular fluid and make the patient worse. Therefore, in persons in slight but chronic water debt, extra salt should never be taken, except in a sudden emergency demanding an extra output of sweat, and then only if ample water were drunk at the same time. Moreover, extra salt also might depress aldosterone secretion, and this would be dangerous. Man has become addicted to salt as a habit, not as a necessity, in the amounts normally consumed. *W. S. S. Ladell, M.D. Abst. from Talk. Brit. M. J.* (*March* 9), 1957.

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The knowledge obtained from tuberculin tests is of value to the community and to the health department in comparing the local rate of infection with that in other areas of the country. Uniform testing of school children is valuable to the health department in focalizing the problem in certain sections of the community, in certain racial groups, and in special geographic regions. While it is desirable to test persons of all ages, this presents certain difficulties and the uniform testing of school children with a uniform dosage of tuberculin appears to provide a satisfactory means of comparing tuberculin sensitivity in various areas. Michael L. Furcolow, M.D., Am. J. Pub. Health, September, 1956.

Insulin and diabetes

A series of glucose tolerance tests has been done on a group of patients after they have convalesced from an acute myocardial infarction. In 19 of these 25 patients, the test indicated incipient diabetes. It is felt that the diabetic state is much broader than has been thought and that most patients with premature atherosclerosis are in effect suffering from a metabolic defect of unknown nature — but one which is part of the spectrum of diabetes on the one hand, and "pure" hyperlipemia, on the other. The question is raised whether or not insulin might have a prophylactic effect in these cases and also whether or not the glucose tolerance test might not be a simple method to pick out individuals who are unduly susceptible to atherosclerosis. *Mark Dodge, M.D. and Marion Sykes, M. T. Atherosclerosis. J. Kansas Med. Soc. Feb.* 1957.

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Talk up to the patient

"My doctor never tells me anything" is the common complaint, nor is pressure of work the only reason for this neglect. We often underrate the patient and doubt his ability to grasp elementary ideas of pathology, and so we withhold explanations which we are sure he will not understand. But experience with nonmedical students has suggested that the laity can be taken much further into the complexities of medical thought than has generally been admitted, and that the promotion of our citizens to adult status might be advantageous to both curative and preventive medicine. There seems to be room for more writing on medical topics addressed to the Pelican-reading classes, and a need also for a monitoring organization that will scour the popular press and issue counterblasts to some of the more dangerous nonsense which is now being printed. *P. E. Brown. Medical Advice in the Lay Press. Brit. M. J.* (*April* 13) 1957.

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The future

As most of our youngsters are taught, so should our oldsters be taught that they must prepare themselves for the future in order to have a pleasant corner in life at any age. *William B. Kountz, M.D. Trends in Gerontology. Pub. Health Rept. Dec.* 1956.

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This list is correct in accordance with the best information obtainable at the date of going to press. County Secretaries are requested to notify The Journal of any changes or errors.

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Adams	Alfred S. Ash, Mendon	Robert C. Murphy, 1416 Maine Street, Quincy
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Northwest	Leonard S. Sluzynski, 2956 Milwaukee Ave., 18	Peter H. Furno, 4124 W. Madison St., 24
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(*Continued on page* 50)

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BOOK REVIEWS



PATHOLOGIC PHYSIOLOGY, MECHANISMS OF DISEASE. William A. Sademan, M.D., F. A. C. P. Professor of Medicine and Chairman of the Department of Medicine, School of Medicine, University of Missouri, Columbia, Missouri. Second Edition: 963 pages; 173 illustrations. W. B. Saunders Company, Philadelphia—London. Price $13.00.

Doctor Sademan is assisted in his work by 25 authors as he states in the preface to the first edition. As the title implies the book "approaches problems of diseases—from the standpoint of disturbed physiology,—analyzes symptoms and signs and the mechanism of their development." He attempts "to promote understanding of how and why symptoms appear."

How successful this volume has been in this attempt is amply evidenced by the fact that a second edition comes off the press so soon after the first edition.

This new edition in general has not changed the approach of the text to the subjects. There has been much revision in many areas. Whole new chapters have been added—genetics, growth and neoplasia, and one on the nervous system. The section on diabetes has been revised and has improved immeasurably the exposition of this subject.

In this particular type of publication there is small need indeed for illustrations and the author has included herein only a few.

In consideration of metabolism and the endocrine glands the "summary" says "the necessity is stressed of considering the function of all the glands of the endocrine system, when one is faced with a disorder that appears to invade only one of the glands."

The internal organs are taken up in sections, each section dealing with that organ and its associated structure. The anatomy concerned in the physiological function to be discussed is described in detail, dealing especially with its properties that are functional. For instance in respiration the normal lung's capacity or distention is explained and from this also its elastic recoil is described. From these factual processes, that are normal, the changes that arise in pathological conditions are not merely stated as being present but the mechanism by which they change are explained in minute detail. This makes very interesting reading.

The consideration of the vitamins, in the section on metabolism and the endocrine glands, is especially interesting.

This volume, exactly as its subject states, deals with the mechanism of disease, and does so with documental material in a most interesting text.

C. P. B.

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CLINICAL USE OF RADIOISOTOPES by William H. Beierwaltes, M. D., Associated

(*Continued on page* 56)



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1. Weil, L. L.: J. Florida Acad. Gen. Pract. 4:9 (July) 1954. 2. Williams, Henry L.: J. Michigan State Med. Society 51:572-576 (May) 1952.



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BOOK REVIEWS (Continued)

Professor of Internal Medicine and Co-ordinator, Clinical Radioisotope Unit, University Hospital, Ann Arbor; Philip C. Johnson, M. D., Assistant Professor of Internal Medicine and Chief, Radioisotope Unit, Veterans Administration Hospital, Oklahoma Medical School, Oklahoma City; and Arthur J. Solari, B. S., M. S. (Physics), Instructor in Radiation Physics, Department of Radiology, Radiation Physicist for Clinical Radioisotopes Unit and Kresge Research Isotope Unit, University Hospital, Ann Arbor. First edition, 456 pages, 126 illustrations. W. B. Saunders Company, Philadelphia, 1957. $11.50.

This very thoroughly integrated text includes clinical, physical and technical details of the entire field of radioisotopes from the basic units of radiation through the most advanced diagnostic methods.

The fourteen chapters encompass all details, including filling out of the Atomic Energy Commission forms giving typical examples and requirements of the Commission for adequate laboratory, as well as a very thorough analysis of the theory and practice of the administration of the more common radioisotopes. This includes, of course, I-131 for hyperthyroidism, both diagnosis and treatment, for diagnosis of euthyroid and hypothyroid states, in the treatment of thyroid neoplasms and the sequelae therefrom.

Further diagnostic studies with iodine including those of gall bladder, liver, blood volume, circulation time, brain tumor diagnosis and many other lesser known examinations are excellently explained.

The uses of P32, Au198, radioactive chromium, cobalt, iron and many seldom used isotopes are also explained very adequately.

A chapter on the biologic effects of radiation explains the bio-genetic reaction of acute and chronic radiation syndromes.

An excellent appendix lists seven tables of useful information.

C. R. M.

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PULMONARY CARCINOMA, PATHOGENESIS, DIAGNOSIS & TREATMENT by Edgar Mayer. M. D. Clinical Professor of Medicine at the Institute of Industrial Medicine, New York Uni-

(Continued on page 58)

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1 "The primary finding of these studies is that meprobamate ['Miltown'] alone . . . produces no behavioral toxicity in our subjects as measured by our tests of driving, steadiness and vision."

Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Ann. New York Acad. Sc. 67:701, May 6, 1957.

2 "Since it [meprobamate—'Miltown'] does not cloud consciousness or lessen intellectual capacity, it can be used . . . even by those busily occupied in intellectual work."

Keyes, B. L.: Pennsylvania M. J. 60:177, Feb. 1957.

3 ". . . the patient never describes himself as feeling detached or 'insulated' by the drug ['Miltown']. He remains completely in control of his faculties, both mental and physical . . ."

Sokoloff, O. J.: A.M.A. Arch. Dermat. & Syph. 74:393, Oct. 1956.

4 "It ['Miltown'] . . . does not cloud the sensorium, and has a helpful somnifacient effect devoid of 'hangover'."

Kessler, L. N. and Barnard, R. D.: M. Times 84:431, April 1956.

5 "In anxiety and tension states, meprobamate relaxes without dulling cortical function to the same extent as the commonly-used barbiturates."

Rindskopf, W., Ravreby, M., Gutenkauf, C. and Sands, S. L.: J. Iowa M. Soc. 47:57, Feb. 1957.

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BOOK REVIEWS (Continued)

versity Post Graduate Center, and visiting physician at University Hospital, New York, and Dr. Herbert Maier, Director of Surgery, Lenox Hill Hospital; visiting surgeon, Bellevue Hospital; associate attending surgeon, Presbyterian Hospital and assistant Professor of Surgery; Columbia University. 540 pages. J. B. Lippincott Company, Philadelphia —$15.00.

"Few non infectious diseases have ever increased so rapidly" as has pulmonary carcinoma in the past 50 years.

Bronchogenic cancer, in one generation has been called "the most violent phenomenon in the history of cancer." Lung cancer is found to have increased by a degree far exceeding that recorded for any of the other varieties of cancer.

This is a very modern volume on a subject that interests every individual who practices medicine or who is interested in medical subjects.

The text summarizes the essential knowledge of lung cancer, as to etiology, pathology, symptomatology, clinical course, diagnosis and treatment.

On a very technical discase the perusal of this volnme will add materially and practically to any physician's knowledge. It is easy reading. It is interesting reading.

The consideration of this subject by the authors is based on the fact that because of the lack of definitive characteristics about incipient lung cancer, diagnosis must begin with suspicion. The last 56 pages are filled with the presentations of cases "in retrospect." Pin pointing errors, pitfalls in diagnosis and presenting lessons learned from them. This portion of the book presents short case histories, numerous x-rays are shown, with the original interpretation and then the errors made in reading are easy in the light of the subsequent clinical course. One cannot peruse these pages without benefit in the lesson emphasized in these pages, namely: thoroughness with which one must scrutinize all patients who present more than a temporary illness.

A very practical portion of this book is that portion directed to therapy. There are individual chapters dealing with surgical therapy, radia-

(*Continued on page* 62)

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BOOK REVIEWS (Continued)

tion therapy, chemotherapy; the use of isotopes and the management of inoperable cases. And also there is included considerable information on the psychiatric care needed because of the chronicity of the disease.

The use of chemotherapy in the management and control of non-resectable lung or recurrent lung cancer receives justifiable space in this book. The use of Nitrogen Mustard is very lucidly handled both from the theoretical and the practical point of view.

Therapy is well summed up as follows:

"X-ray therapy is the major method of palliation in non-resectable primary or recurrent lung cancer. Nitrogen Mustard, TEM, and related compounds and the adrenocortical hormones, may be of benefit, but the response is usually brief and there is no assurance that treatment appreciably prolongs life. It is essential to progress, however, that we intensify our attack. From the patient's point of view, maintain an aggressive therapeutic approach—to 'Sustain Moral'."

As stated above this book is interesting reading.

C. P. B.

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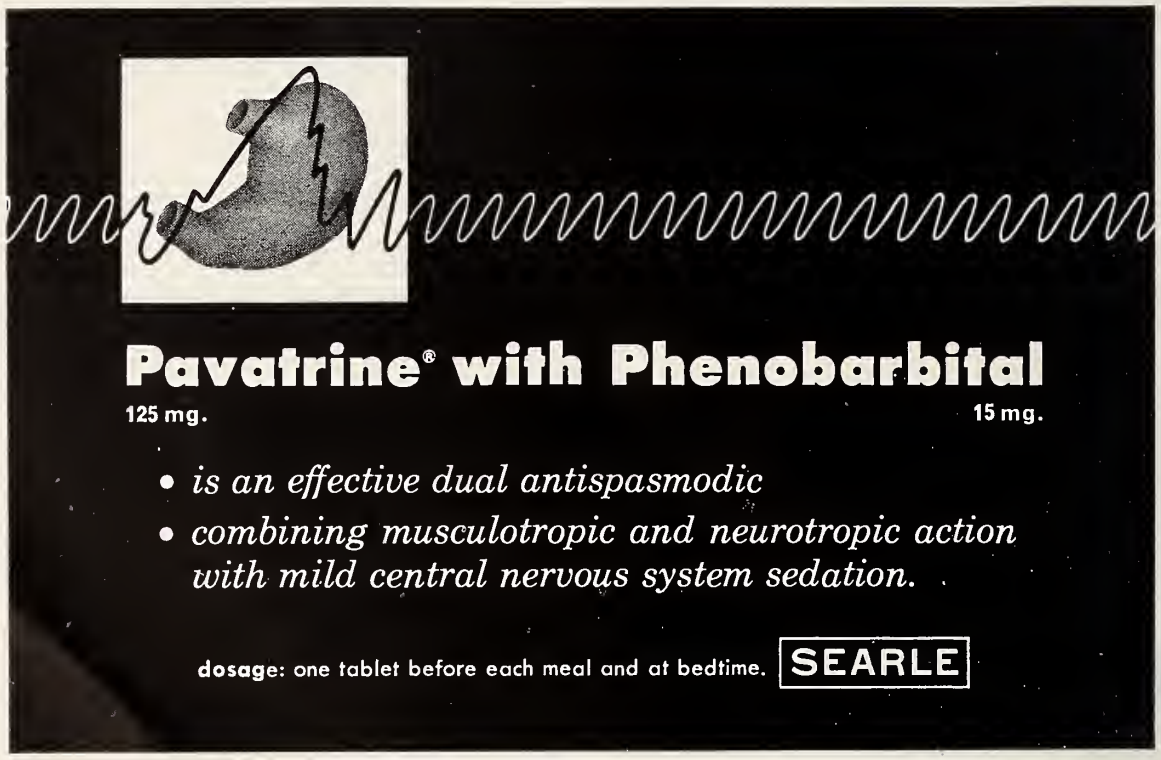
The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

DISEASES OF THE NOSE, THROAT AND EAR. By Howard Charles Ballenger, M.D., F.A.C.S., Professor Emeritus of the Department of Otolaryngology, Northwestern University Medical School, Chicago; Surgeon, Department of Otolaryngology, Evanston Hospital, Evanston, Illinois, and John Jacob Ballenger, B.S., M.S., M.D., Associate in the Department of Otolaryngology, Northwestern University Medical School, Chicago. 10th edition. 968 pages. 500 illustrations and 11 plates in color. $17.50. Lea & Febiger, Philadelphia.

PRACTICAL GYNECOLOGY. By Walter J. Reich, M.D., F.A.C.S., F.I.C.S., Attending Gynecologist and Section Chief, Fantus Clinics of the Cook County Hos-

(*Continued on page* 64)

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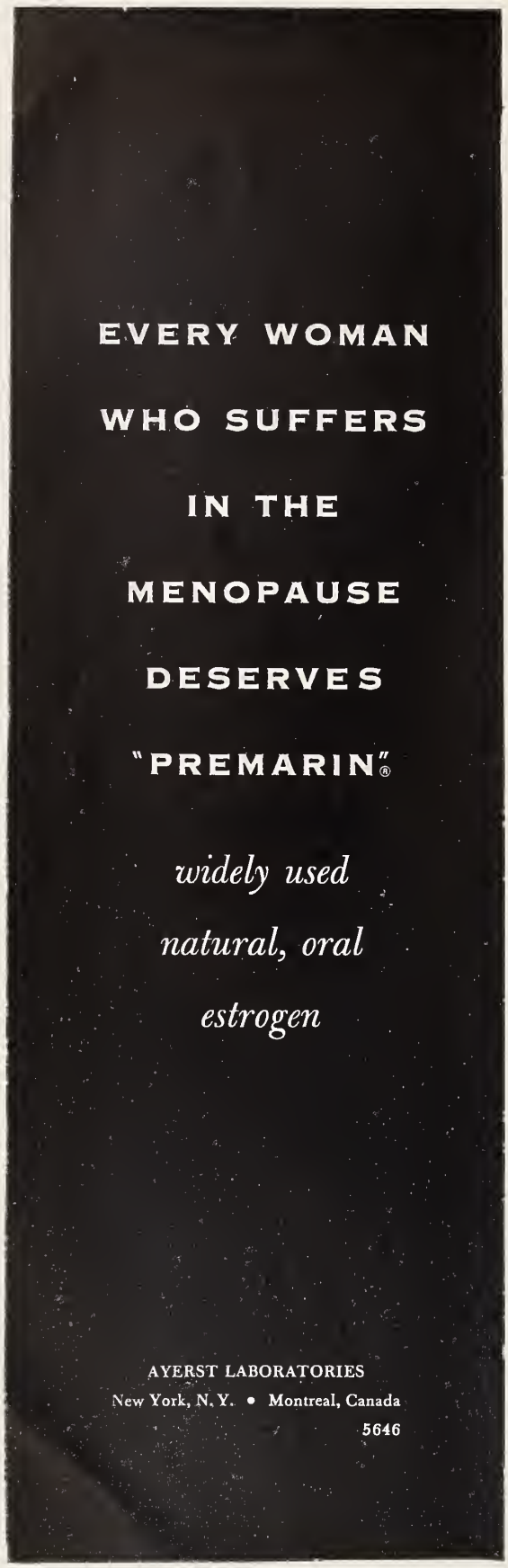
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pital, and Mitchell J. Nechtow, M.D., F.A.C.S., F.I.C.S., Associate Attending Gynecologist, Cook County Hospital and Fantus Gynecologic Clinic. Second edition. 284 illustrations, including 68 subjects in color. J. B. Lippincott Company, Philadelphia and Montreal. $12.50.

RYPINS' MEDICAL LICENSURE EXAMINATIONS. Topical Summaries and Questions. By Walter L. Bierring, M.D., M.A.C.P., M.R.C.P., Edin. (Hon.), Former Member, National Board of Medical Examiners, American Board of Internal Medicine, Iowa State Board of Medical Examiners. With the collaboration of a review panel. Eighth edition. J. B. Lippincott Company, Philadelphia and Montreal.

GIFFORD'S TEXTBOOK OF OPHTHALMOLOGY. By Francis Heed Adler, M.D., Wm. F. Norris and George E. DeSchweinitz, Professor of Ophthalmology, University of Pennsylvania Medical School. Sixth edition. Illustrated with 277 figures and 26 color plates. 499 pages. W. B. Saunders Company, Philadelphia and London, $8.00.

MODERN THERAPY IN NEUROLOGY. Edited by Francis M. Forster, M.D., Dean and professor of Neurology, Georgetown University School of Medicine, Washington, D. C. Foreword by H. Houston Merritt, M.D., Professor of Neurology, College of Physicians and Surgeons, Columbia University; Director of New York Neurological Institute, New York, N. Y., The C. V. Mosby Company, St. Louis, $12.00.

THERAPEUTIC EXERCISE FOR BODY ALIGNMENT AND FUNCTION. By Marian Williams, Ph.D., Assistant professor of physical therapy, Department of Allied Medical Sciences, School of Medicine, Stanford University, and Catherine Worthingham, Ph.D., Director of Professional Education, The National Foundation for Infantile Paralysis, Inc. Exercise illustrations by Harold Black. 127 pages. W. B. Saunders Company, Philadelphia and London, $3.50.

HEMORRHAGIC DISEASES. By Armand J. Quick, Ph.D., M.D., Professor of biochemistry, Marquette University School of Medicine, Milwaukee, Wisconsin. 451 pages. Illustrated. 31 tables. 1st edition. Lea & Febiger, Philadelphia 6. $9.50.

EPILEPSY, Grand Mal, Petit Mal Convulsions. By Letitia Fairfield, C.B.E., M.D., D.P.H., Philosophical Library, Inc., 15 E. 40th Street, New York 16. 159 pages. $4.75.

PHYSICAL DIAGNOSIS. Correlation of Physical Signs with Certain Physiological and Pathological Changes in Disease. By Simon S. Leopold, M.D., Professor of Clinical Medicine; School of Medicine and Graduate School of Medicine, University of Pennsylvania. Second edition. 537 pages. 379 illustrations and 25 color plates. W. B. Saunders Company, Philadelphia and London, $9.00.

MEDICINE IN CHICAGO, 1850-1950. A chapter in the social and scientific development of a city. By Thomas Neville Bonner, Associate professor of history and chairman of the Department of Social Science at the University of Omaha.

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Sir,

I recently had the misfortune to spend a period in one of your hospitals. During that time my most reasonable requests were refused or met grudgingly after considerable delay. Despite my loud protests I was frequently left half an hour or more in a state of extreme hunger and when I dropped such meager articles as were supplied to relieve my boredom, little effort was made to restore them. Furthermore, how would the Minister care to sit for an hour in a wet nappy? I was admitted for the investigation of a little mild vomiting. It took two weeks and much painful bloodletting to discover that I don't vomit. I regurgitate and like it. I can assure you, Sir, that I shall not let this matter rest. Already, since returning home, I have managed to arouse much local indignation.

I am, etc.

In England Now. Lancet, Sept. 8, 1956.

‹ ›

Codices of the Aztecs

The books, or codices, of the Aztecs, generally made of paper from the fiber of the wild fig tree and folded like screens of maps, were painted with figures in many colors. As the Aztecs had no alphabet, their "writing" consisted of conventionalized pictures, together with certain generally understood symbols which recorded history, religion, and records. Only 13 of these codices are still in existence. One of these is the earliest American medical book, an Aztec manuscript containing native cures for hundreds of ailments such as headache, insomnia, falling hair, toothache, and even hiccups. To cure a cold in the head, the patient sniffed a herb with the tongue twisting name of tzompilihuizxhuitl, meaning "thorny-cold-in-the-head-plant." *The Aztecs. Pan American Union.*



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‹ ›

Until recently the emphasis of tuberculosis control programs has been centered on mass surveys, mobile roentgenographic units, and hospital admissions, while a segment of the population with one of the highest rates of infection has been somewhat neglected. Continuous case-finding programs in prisons offer a fertile field for the control of tuberculosis for several reasons. The increased prevalence rate of the disease in prisoners makes such programs much more rewarding than are those which are carried out in the general population. Harvey I. Meyers, M.D., George Jacobson, M.D., and Frank W. Oechsli, M.D., Am. Rev. of Tuberc., Oct. 1956.



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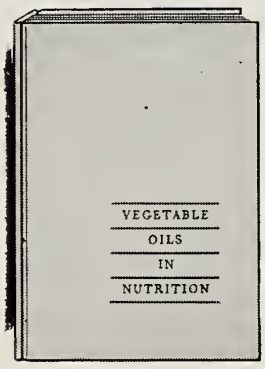
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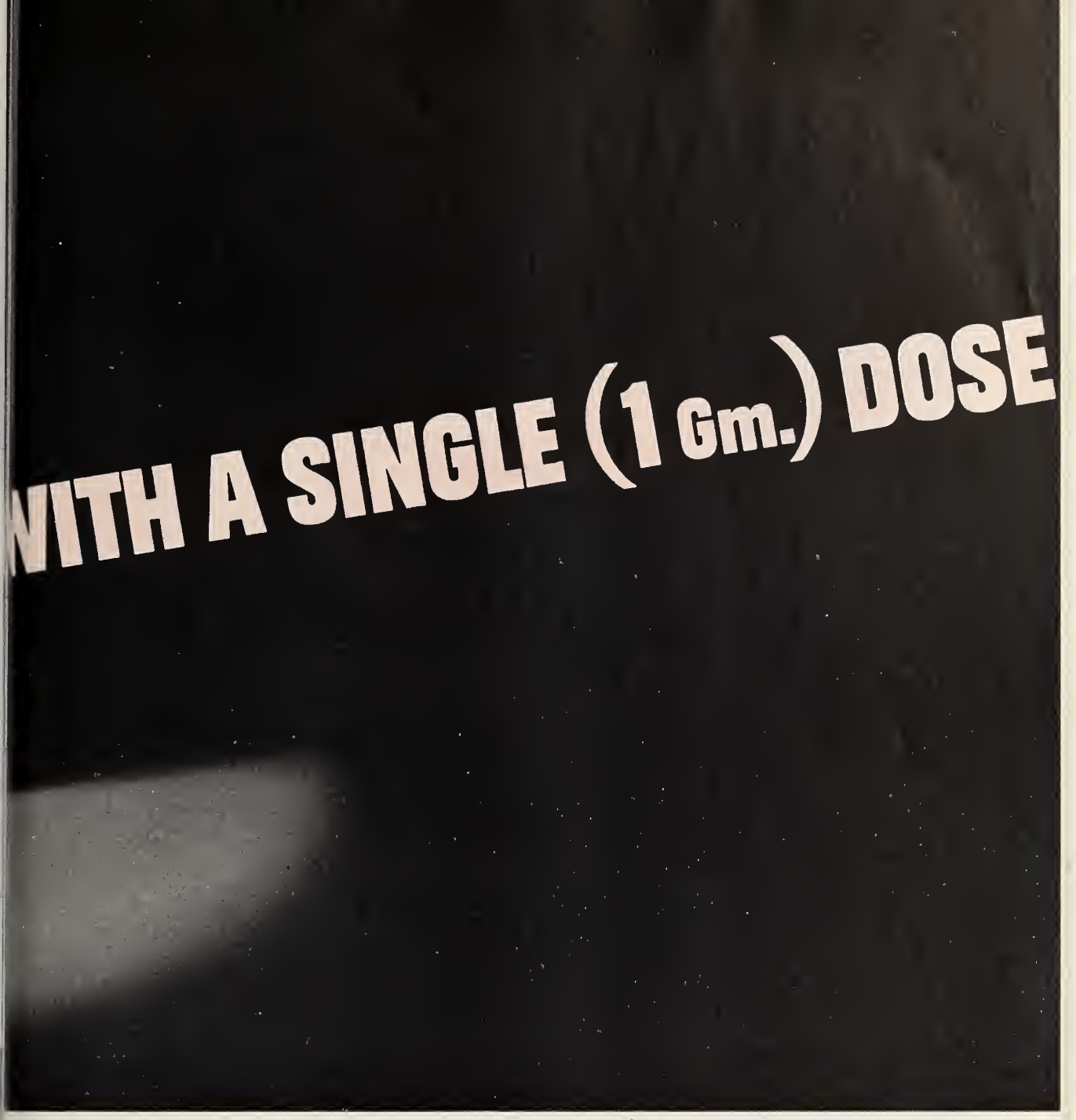
Syphilis

There is no natural immunity to syphilis nor development of latent immunization without frank and detectable disease. The disease, however, is by no means so virulent today as it was centuries ago, when the early stages frequently caused death and when the late forms caused extensive and horrible damage to both skin and bones. As long as the patient has syphilis, a new infection cannot be acquired, except that superinfection is possible before and for a few days after the appearance of the chancre. What is known as cure may be clinical and serological rather than biological since reinfection of persons who are cured after the disease has become well established has never been proved satisfactorily. If cure is achieved shortly after the appearance of the chancre, subsequent reinfection is quite possible. In this latter case, cure may be biological in the sense that every spirochete has been killed. Whatever the cause of the resistance to reinfection, it has not been possible to take advantage of it for the artificial production of active or passive immunity. *Gaylord W. Anderson, M.D. and Margaret G. Arnstein, R.N. Communicable Disease Control, Macmillan Co.*

‹ ›

An interesting question

Many years ago I was dining out with the late Sir William Hale-White and he told me the following story: When he was a young man he once asked Sir Thomas Barlow which came first in pulmonary tuberculosis, the fine crepitations or the impairment of percussion. Barlow replied: Hale-White, it is very interesting that you should ask me that question because when I was a young man I once asked Sir Andrew Clark. Andrew Clark replied: Barlow, it is very interesting that you should ask me that question because when I was a young man I once asked Theodore Williams. Theodore Williams replied: Clark, it is very interesting that you should ask me that question because when I was a young man I once asked Louis in Paris. And Louis replied: Williams, it is very interesting that you should ask me that question because when I was a young man I once asked Laennec. And Laennec said that the fine crepitations came before the impairment of percussion. *Sir Henry Tidy. Lancet, Oct. 27,* 1956.



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1. Boger, W. P.; Strickland, C. S.; and Gylfe, J. M.: Antibiot. Med. & Clin. Ther. 3:378 (Nov.) 1956.

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Is man a machine?

Finally, if I may fly high for a moment, I cannot see how you can practice medicine on a basis of reason unless you first formulate, for your private use, some sort of philosophy of life and in particular, decide whether you believe in "man, a machine" or "man, not a machine." Either belief is tenable and I am not going to argue about their truth but it must be very difficult to practice on the basis of the first. Practice is easier if you hold that we all have a mind which is not the brain, nor yet a function or secretion of it, but a separate entity. You need not attempt to define it closely so long as you are prepared to assume its existence quite frankly, call it by its name, speak of it to your patients (who have never troubled to think whether they believe in it or not), and assume that it has its own primary disorders which express themselves in bodily symptoms. If the word "brain," which should mean that thing inside the skull, is used for intellect or sanity and the word nerves which should mean - well, nerves (motor, sensory, or mixed) is used to mean anxiety, fear, temperament, or the state of being in love, then rational dealing with the whole vast class of psychosomatic disorders becomes impossible and the confusion in the mind of the patient is very likely to spread to the doctor. Recognize the mind, call it by its name, put it on the table between you and the patient, and you can begin to think and talk good sense about these things. *L. W. Batten, M. B. Lancet, Aug.* 25, 1956.

‹ ›

Variations and loss of sensitivity to tuberculin have been observed in the course of some diseases. These changes are usually of a transitory nature, and tuberculin hypersensitivity returns with the improvement or recovery of the patient. The tuberculin reaction which may be slight or absent in those suffering from far advanced tuberculosis or tuberculous meningitis may return in those whose condition improves under antimicrobial treatment. Joseph D. Aronson, Helen C. Taylor, Daniel L. Kirk, Am. Rev. Tuberc., July, 1956.

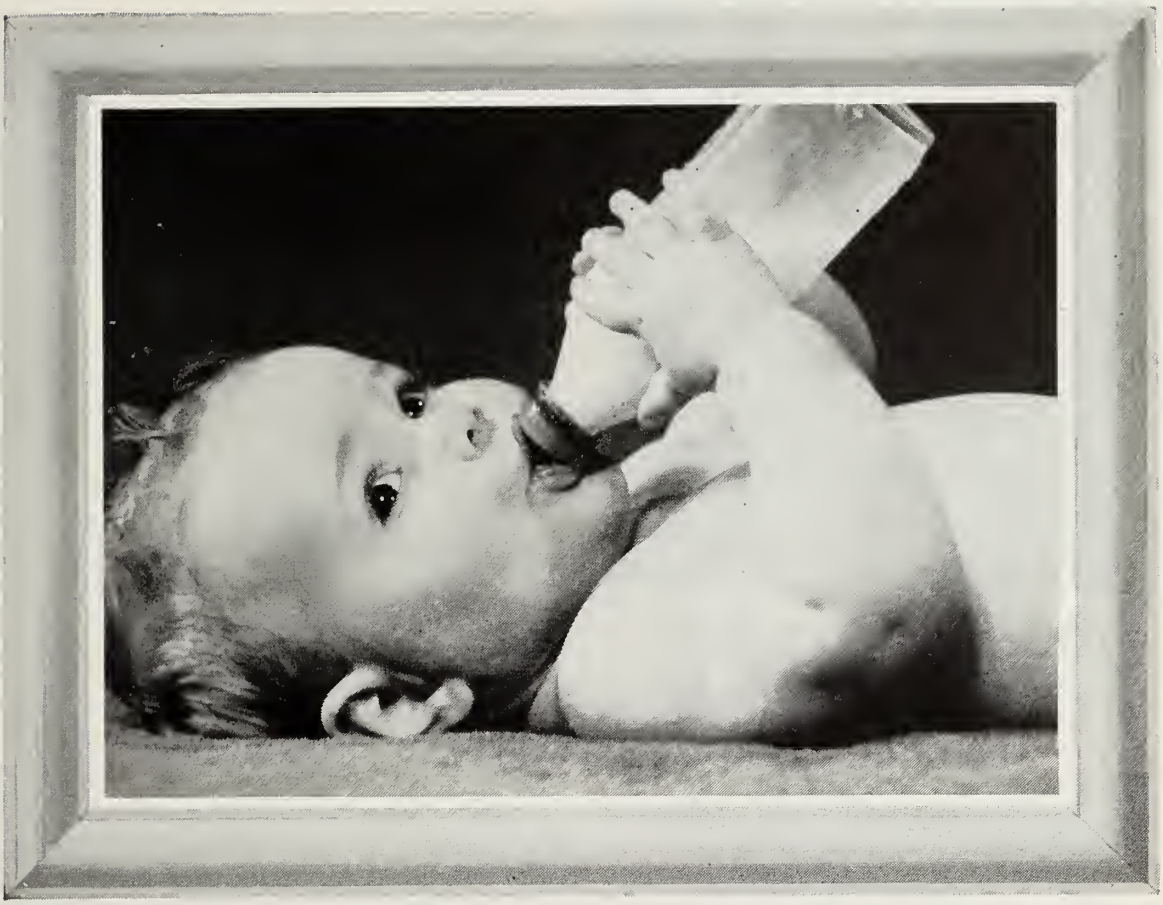
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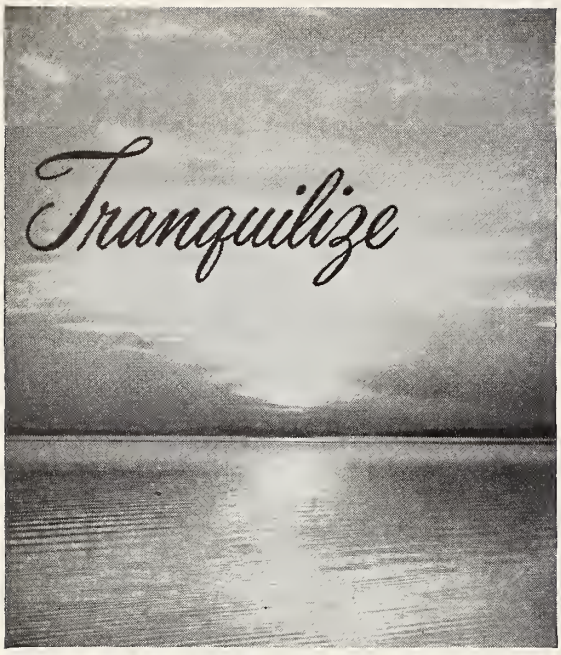


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It happened in 1776

In Grose's *A Classical Dictionary of the Vulgar Tongue,* (1795), cundum is defined as "the dried gut of a sheep, worn by men in the act of coition, to prevent venereal infection; said to have been invented by Colonel Cundum." The entry adds the following details: "These machines were long prepared and sold by a matron of the name of Phillips, at the Green Canister, in Half-moon Street, in the Strand (sic). That good lady, having acquired a fortune, retired from business; but learning that the town was not well served by her successors, out of patriotic zeal for the public welfare, she returned to her occupation; of which she gave notice by divers handbills, in circulation in the year 1776. Also, a false scabbard over a sword and the oil-skin case for holding the colors of a regiment." *Julian Huxley. Material of Early Contraceptive Sheaths. Brit. M.J. March* 9, 1957.

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Retirement from what?

Recognition of these facts imposes an obligation on persons being retired at 65 for reasons other than disability or illness, as well as upon their advisors, to see that these older men and women maintain their civic responsibilities by seeking a useful active life for their remaining years. Retirement is an unfortunate term as it implies withdrawal from everything. It is sometimes difficult to get this idea out of their minds. One man who formerly read his daily paper, listened to ball games on the radio, did crossword puzzles, and conversed with his colleagues, came to a friend's house during the first week of his retirement from business and sat there listlessly. When his friend pointed out that such interests were immediately available and he could now have more time for them, the recently active business man looked up sadly and exclaimed in a whispered voice, "But I have retired from all that." *Panel Meeting on Problems of Retirement. Bull. New York Acad. Med. Jan.* 1957.

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Research is like a giant spotlight that goes inching over the black night sky. No one can be sure when it will turn up something of importance. *AARMS Forward, Winter* 1956.

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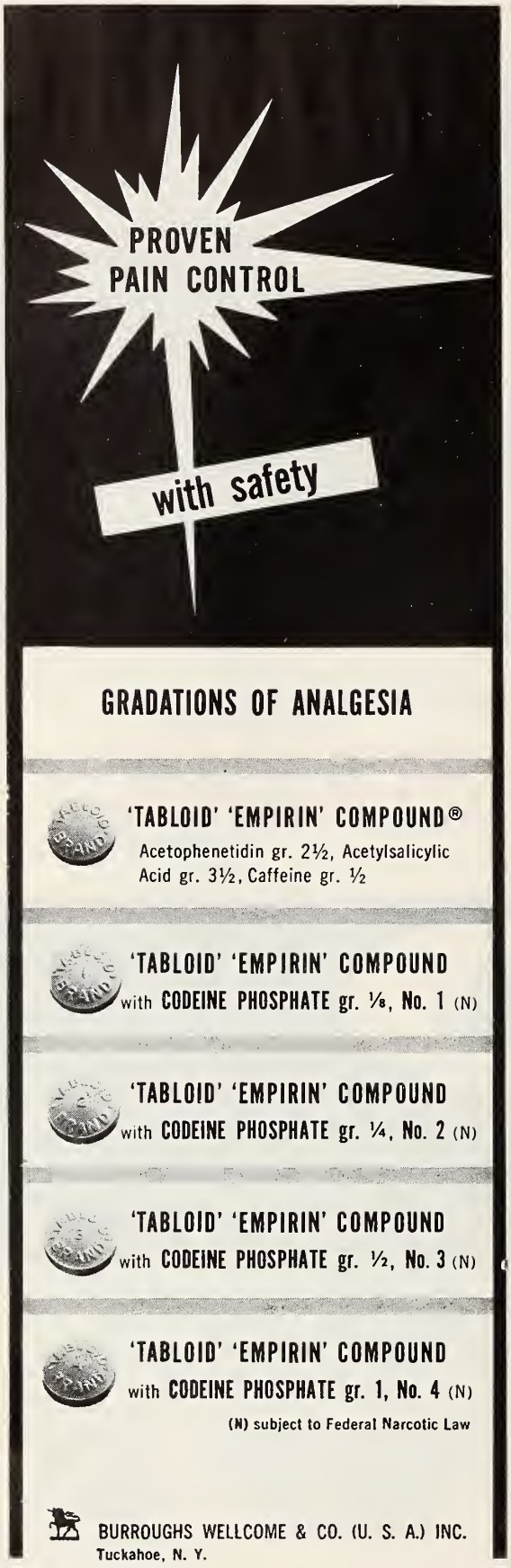
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The division of all work

The Earl of Verulam spoke on the scope for a new approach by management. There were five categories into which all jobs may be divided. (1) Sedentary. There was no responsible source of information readily available about the best way to sit at work. "Anatomical seats" were cheaper than latex-sponge seats, but they seemed to imply that all anatomies and all jobs required the same type of seat. The adjustable backrest was used only as a rest and not as a support for work. (2) Peripatetic. The machine builder makes a virtue of the fact that all of the controls are on one panel. It was probably healthier to exercise all the limbs most of the time than to overemploy a few muscles all the time. "They shall walk not faint," said Isaiah. (3) Peculiar. Many people adopted unnatural working positions — for example, the coal miner, the cowman, and the clockmaker. Coal cutters allowed the miner to move about more, cowmen stood at a lower level than the cows, and the relative positions of clockmaker and his supplies of components were changing. (4) Asymmetrical. The human body was biologically an organism that was bilaterally asymmetrical. Machine layouts compelled a man to work in a lopsided manner. (5) Mobile. One aspect of safety on the roads was the color of the vehicles. Manufacturers of cars chose colors that were smart or fashionable; and lorries were colored to suit advertising needs. *Research in Occupational Health. Lancet, Oct.* 6, 1956.

Religion and stability

Strong and practicing religious convictions are a powerful contribution to emotional stability. I would never counsel any man to embrace religion simply because it would be good for his mental health. Such a faith would be superficial and insincere, a house built on sand. But I do advise that you think the matter through and decide what philosophy of life can give ultimate meaning to your existence. You can accept religious faith as the answer — as I have — or you can reject it; but you cannot safely sidestep a decision about it. I have never seen a really well adjusted person who had not resolved the question of his own religious beliefs. *Louis Cassels, quoted by Robert H. Felix, M.D. Nation's Business, Sept.* 1956.

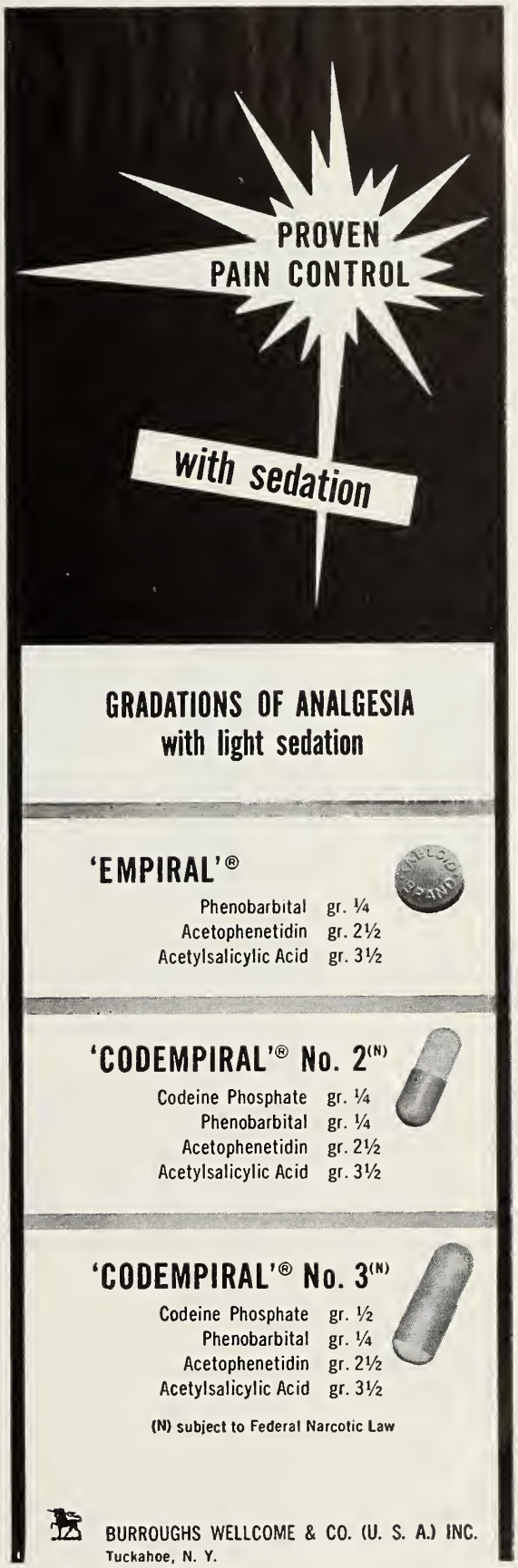
Indemnity payment discourages cure

There are a number of deterrents to the development of Workmen's Compensation Laws. Many of our states still radically limit the medical benefits which an employer or compensation carrier must furnish an injured worker. In these same states the compensation law does not provide sufficient medical benefits to pay for the cost of the physical restoration of the seriously injured. Surprisingly little added premium would provide a tenfold increase in medical benefits. Second, the archaic concept of indemnity payments for scheduled partial disabilities offers no incentive to rehabilitation effort, usually ignores the loss of earning capacity which more truly represents the loss resulting from the injury, and actually may encourage the worker to retard his recovery. Schedule awards bear no relation to the true impact of the injury on a man's earning capacity. Third, total disability benefits are inadequate and in some instances deter rehabilitation efforts. Only a few of the compensation acts provide lifetime benefits for these unfortunates. In the acts of some states, certain injuries such as a loss of both hands or both eyes are conclusively presumed to represent permanent total disability, whether or not rehabilitation returns the man to gainful employment. There is thus no financial incentive to rehabilitation effort. There are no special provisions of any kind for rehabilitation of occupational injury cases in over two-thirds of our compensation acts. Available rehabilitation facilities, although increasing, are still woefully inadequate. There is serious need for concentrated cooperative effort by management, labor, and insurance groups toward solving this problem. *J. F. McCahan, M.D. Rehabilitation's Contribution to Industrial Health. Am. A. Ind. Nurses J. March* 1957.

‹ ›

The four D's

A high proportion of accidental deaths from carbon monoxide poisoning are associated with various predisposing conditions in the victim. which have been described collectively as the four D's — the decrepit, the diseased, the drugged, and the drunk. *F. S. Fiddes, M. D. Brit. Med. J. Sept.* 22, 1956.



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The Month in Washington



Washington, D. C.—The 85th Congress is in the final weeks of its first session with prospects that it will enact few major medical bills this year, but that next year will be a different story. On at least half a dozen important measures action has been postponed, with the understanding that the issues will be fought out in 1958.

Circumstances prevented any delay on one bill that is of considerable importance to the younger doctors—a new version of the doctor draft act. It had to be enacted by July 1, the Defense Department insisted, or not enough doctors would be available to maintain the military medical services at an acceptable level.

The problem is that the Armed Forces require a higher ratio of physicians to troops than exists between physicians and the general population. Without some special law, the services would either have to make out with fewer doctors than they say they need, or draft thousands of nonphysicians merely to obtain the doctors who are in the particular age groups.

This scheme was devised: Amendment of the regular draft act to allow the call up, to age 35, of the necessary numbers of doctors from among those who had received educational deferments; they could be called because they are physicians, not because they are of a certain age. Also, the national, state and local Medical Advisory Committees of Selective Service would be continued, as would a number of provisions in the original act that protect the rights of drafted doctors.

As Congress moved toward adjournment, prospects also were that it would enact a bill to help out some states caught in a financial squeeze because of a new act, passed last year but not scheduled to go into effect until July 1, 1957, to increase federal payments for the medical care of persons on the state-federal public assistance rolls.

Under the old system, states could use the U.S. dollars to pay directly to the individuals for their medical care, or directly to the vendors of medical service—hospitals, physicians, dentists. Many states, adopting the second plan in all or part of their counties, used the federal money to help maintain pooled funds, which support various medical care programs.

All U.S. money paid out under the new act must be used in the form of vendor payments—that is, not turned over directly to the public assistance cases. At the same time, the law as originally passed stipulated that any money received under the old plan henceforth would have to be handled as "recipient payments," that is going directly to the persons on public assistance rolls.

A number of states thus faced the prospects of drastically revising their carefully-established medical care programs or sacrificing large amounts of federal money. Congress came to their rescue by means of a bill that would allow them to use the old money as before, yet take full advantage of the new federal program.

In the closing weeks of the session, however, two major medical bills were making little, if any progress—those for federal grants to med-

(*Continued on page 32*)

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ical colleges to build teaching facilities and for initiating a program of health insurance for federal civilian employees.

A number of bills had been introduced on aid to medical education, representing virtually all the viewpoints in Congress and the administration, but nothing much was happening. Here one factor was the economy drive, which was not too successful in cutting the administration's health budget, yet which virtually precluded any new programs involving large appropriations.

On federal employee health insurance, these long-standing differences of opinion still blocked any compromise: Should emphasis be on basic health insurance, or on major medical (catastrophic) coverage? Should U.S. payroll deductions be permitted, or would this open the door to demands for many other payroll deductions, such as for union dues? What safeguards could be set up to prevent either the commercial insurance companies or the nonprofit organizations (union plans and Blue Cross-Blue Shield) from gaining a dominant position?

On these two major bills—as well as on many others, sponsors were not too discouraged. Already they were making plans to press them still more vigorously next year when Congress, looking toward the fall elections, may be more responsive.

NOTES

Doctors are asked by PHS to be on the alert for a new type A influenza strain expected to work its way into this country from the Far East. Details from state health departments.

National Library of Medicine officials were still hopeful, as the end of the session neared, that Congress would vote enough money to start constructing the library's new building next year.

For the first time the U.S. contribution to WHO this year is expected to drop to a third of the total WHO budget. In dollars, however, the U.S. share continues to go up, as the charges to other countries.

The Export-Import Bank is making long-term, low-interest loans to some Central American countries to build health facilities, such as hospitals and sewage plants.

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The intermediate position

Scientists may be divided into three groups. There are those who believe that at every stage in scientific development it is necessary to provide the best available generalizations as a guide to effective work, both in the application of knowledge to human needs and in the planning of future research. At the other extreme are those who feel that the only valuable scientific activity is to concentrate on some significant facet of knowledge until the facts are incontrovertible and are expressible in some general statement preferably mathematical in form, that is acceptable to all competent workers. Then we have available a defined unit of knowledge which can be used reliably when the time comes to apply the knowledge in any field where it is required. The great majority of scientists take an intermediate position, usually finding their immediate interest in the detailed study of a chosen field, but interested in learning of the emergence of general pictures in the various wider fields. *Sir Macfarlane Burnet, M.D. Cancer — A Biological Approach. Brit. M.J. Apr.* 6, 1957.

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Air Embolism Associated with Pregnancy and the Puerperium

Jack D. Brodsky, M.D. and Carl Greenstein, M.D., Champaign

We encounter air embolism infrequently in the practice of obstetrics and gynecology because by the time it is recognized as such, the consequences usually are lethal. Sublethal air embolism probably occurs with some frequency but is seldom recognized as such. Even though the incidence is low, we must learn more of its prophylaxis and treatment because of the extremely high mortality rate associated with the conditions.

Collins and Batson[1] analyzed maternal deaths at the Charity Hospital of New Orleans from January 1, 1949 through December 31, 1952 and found that 20 occurred during 16,207 deliveries, an incidence of 0.123% or 1.23 deaths per 1,000 deliveries. Embolism accounted for 7 of the 20 deaths (35% of all maternal deaths).

Amniotic fluid embolism	3	or 15%
Air embolism	1	or 5%
Phlebothrombosis	2	or 10%
Suppurative pelvic thrombophlebitis	1	or 5%
	7	35%

Waldrop[2], as recently as 1953, reported less than 20 cases of air embolism associated with term deliveries and during the puerperium in the literature. Two of these cases were associated with cesarean section at term[3,4]. Four occurred during labor[5, 6, 7, 8]. Four occurred well along in the puerperium[9], the inciting factor being the assumption of the knee-chest position. There were four cases early in the postpartum period, with no known causative or precipitating factors[7, 10, 3]. One case occurred on the eighth postpartum day without known cause[7]. Two cases occurred during the expulsive stages of labor and no complications of pregnancy or labor were known to be present[7, 2].

The first record we have of air embolism being recognized as such was in 1667 when Ride produced death in cattle by blowing air under pressure into the juglar veins. The first recorded case of air embolism in humans was written by Beauchesne in 1818 after he had observed its occurrence during the removal of a neck tumor[11].

There are only two types of air embolism: arterial and venous. The venous is by far the most common type. Air enters the peripheral veins and flows via the inferior or superior vena cava to the right atrium and the right ventricle, thence to the pulmonary arteries. In arterial embolism the site of entry is the pulmonary

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vein from which air enters the left atrium, left ventricle and eventually the systemic circulation.

It is impossible to predict accurately the quantity of air required to produce serious symptoms in a given case of air embolism. Some authors state that as little as 15 cc. of air may be fatal[8]. Others have injected rapidly as much as 490 cc. of air intravenously into humans without any untoward effects. However, it would seem logical to assume that the greater the volume of air, and the more rapid its entrance into the body, the greater the possibility of death. Richardson, Coles and Hall, basing their assumptions on experimental air embolism produced in small animals, estimated that it would require the rapid injection of 500 cc. or more of air to kill a human being[12].

There are two prerequisites for the development of air embolism: (1) A vessel in a state of partial collapse, either because its wall is only partially opened or because its fascial attachments prevent retraction of the cut end; and (2) suction produced by negative intravenous pressure or the introduction of air under positive pressure into a blood vessel.

These conditions are met during accomplishment of many therapeutic procedures. Among the most common are the establishment and maintenance of pneumothorax, pneumonectomy, lobectomy, thyroidectomy, radical breast dissection, puncture of the paranasal sinuses[13], fractures of the long bones, intravenous infusions, perirenal insufflation[14], introduction of air into a joint cavity or the bladder[15]; and, of far more interest to obstetricians and gynecologists, the induction of labor or abortion, manipulation of the pregnant or puerperal uterus and, in gynecology, following intravaginal insufflations, douches, dilatations and curettages, pneumoperitoneum and peritoneoscopy, culdoscopy, and tubal insufflation[1, 16].

There is no uniformity of opinion on the mechanism of death in the venous type, but it seems to be a combination of factors: (1) Noncompressible air replacing the compressible blood in the right heart, causing cardiac standstill; (2) embarrassment of heart function due to the actual air bubble or to the frothing of the blood which prevents the transfer of oxygenated blood from the right ventricle to the left atrium; (4) coronary artery embolism; and (5) ischemia of the vital brain and central nervous system centers.

The signs and symptoms of this syndrome usually are extremely dramatic. Marked apprehension, tachycardia, cyanosis, dyspnea, and sudden shock are noted almost immediately. The pulse becomes very irregular. If air is present in the large veins, hissing sounds may be heard over the precordium. A diagnostic feature that has been described is a peculiar, gurgling, churning and rushing heart sound, which has been attributed to the churning of the frothing blood within the heart chambers. If air escapes into the arterial circulation, there is blindness caused by air in the retinal vessel which may be seen with an ophthalmoscope. There may be scattered areas of skin blanching due to interference with capillary circulation.

Death may be instantaneous or may occur within several hours. About 15 to 50 per cent of all cases of air embolism terminate fatally. If the patient survives the first 15 minutes, prognosis is good. If she survives the first hour, usually coma and paralysis will clear.

A knowledge of the pathological anatomy leads to rational but usually ineffective therapy. Recommended treatment is the aspiration of air from the right ventricle, and, in an attempt to replace the frothy mass of air and blood in that chamber, 50 to 100 cc. of normal saline should be injected into that chamber. To be effective, this procedure must be done almost as soon as the accident occurs. Consequently, prompt recognition is essential if there is to be any hope for recovery. Artificial respiration should be given, utilizing inhalations of 100 per cent oxygen to facilitate absorption of nitrogen bubbles in the circulation. Cardiac and respiratory stimulants are administered. The patient should be turned on her left side to allow the air to rise above the level of the blood in the right heart. Other supportive measures include antispasmodics and constant intravenous infusions of blood, plasma, or other fluids. In spite of this vigorous therapy, the end result is usually fatal.

It should be emphasized that if air embolism is suspected as a cause of death, an autopsy should be done. It is necessary to ligate the great vessels before removing the heart from the chest cavity and then to open the heart under water at which time emboli are seen to rise

from the chambers. If an autopsy is unobtainable, then the right ventricle should be aspirated as soon as possible postmortem in an attempt to establish the presence or absence of air therein.

Air embolism is of special interest to obstetricians and gynecologists. It has long been known that air embolism might be dangerous to the parturient. Legallois first suggested that air might enter the circulation by way of the uterine veins as early as 1829. Cormack[17] in 1850 and May[7] in 1857 described the first cases of air embolism associated with pregnancy.

Air embolism commonly follows criminal abortion where air is used as the abortifacient agent. This is especially true when a low-lying placenta provides venous sinuses for the ready introduction of air into the systemic circulation. Placenta previa at term occasionally is associated with air embolism, especially if a version is performed. Several patients expired instantly when a central placenta previa was being ruptured to obtain a foot. Osborn and Dawson[3] reported three cases of air embolism. Their first patient had a classical cesarean section performed under gas-oxygen-ether anesthesia because of a cephalopelvic disproportion. There was no mention of the location of the placenta but at the time of the uterine incision the patient suddenly went into shock and died three hours later. Autopsy revealed air bubbles in the right heart. Their other two cases died early in the postpartum period and no known causative factors, other than a partial inversion of the fundus in one case, could be found. Mylks, Robinson and Brown[6] reported a case of air embolism associated with the first stage of labor following premature separation of the placental edge. One and one half hours before delivery, the patient went into shock, became restless, and was cyanotic. She died one half hour after delivery of a stillborn infant. At autopsy, air bubbles escaped when the vessels of the breast were cut. Air bubbles also were present in the right ventricle. Cody and Wintrow[4] reported a fatal case of air embolism in which the patient expired 65 minutes following a low-flap cervical cesarean section performed because of a central placenta previa. Open blood vessels on the inner surface of the uterus could not be demonstrated as they rarely can[18].

Many cases may be found in the medical literature concerning death resulting from vaginal insufflation in both the gravid and nongravid. Because of the effectiveness of this therapy, vaginal powder insufflators are in daily use for the treatment of trichomonas and monilial infections. Two cases of fatal air embolism following this type of treatment were reported by Martland[19].

The first case, nonobstetric but very graphic was that of a 21 year old white female who complained of a slight leucorrhea and intense vulvar itching. She had just completed a menstrual period. The physician placed her in lithotomy position on the examining table and the glass tip of an old style vaginal powder blower containing Stovarsol® powder was inserted between the labia and the bulb was then compressed about 12 times (this later proved to be about 300 cc. of air). After the last compression of the bulb, the patient complained of feeling faint, became pulseless, breathed about 12 times, and died on the examining table. Autopsy, performed approximately 14 hours later, showed an intact hymen of the cribriform type with three small openings, the largest being 8 mm. in diameter. The uterus appeared normal except for irregular mucosal hemorrhages in the endometrium of the posterior uterine wall just above the cervix. The inferior and superior vena cava and the right side of the heart were distended with air bubbles and frothy blood. There did not appear to be any air in the left heart. Although the exact point of entry of air into the venous circulation could not be anatomically demonstrated, the recent hemorrhage in the cervical canal and lower uterine segment was presumed to be the point of entry. The patient's recent menses probably accounted for the hemorrhagic lower uterine area.

Martland's second case was that of a 27 year old colored primipara, six months pregnant, who complained of pruritus vulvae. The physician inserted the metal tip of the powder insufflator into the vagina and used Vioform® as his medication. The attached rubber shield was pressed tightly against the labia and the bulb compressed seven or eight times. Toward the latter part of the insufflation, the patient suddenly sat up, complained of being dizzy, and fell back dead. An autopsy 18 hours later revealed a preg-

nant uterus which was at the level of the umbilicus and markedly tympanitic over its entire anterior surface. The entire amnion and chorion was separated from the uterine wall except at the placental site. On the anterior surface of the uterus lay an air pocket 3 to 4 cm. in thickness which was causing the tympanitic note. The placenta was implanted on the posterior wall of the uterus. Near its upper and left edge there was considerable hemorrhage into the placenta, and it was partly torn by dissecting entrapped air. This allowed air under pressure to rush into the open maternal venous sinuses. The metal tip of the insufflator must have rested directly against the soft cervix of the pregnant uterus because there was considerable powder blown into the uterus. The rubber shield of the insufflator which was held closely against the external genitalia prevented the escape of excessive intravaginal air.

Similar fatal cases have been reported by Pierce[20], Brown[21], Partridge[22], and Breyfogle[23].

It would be unfortunate if an effective method of therapy should be classified as dangerous or should fall into disrepute because proper technique was not used. In reviewing the histories of these fatal cases, one cannot help but observe a common denominator. By pressing a shield tightly against the labia, too much pressure is allowed to build up within the vagina, thus forcing air under relatively high pressure into a vein. The air enters the uteroplacental veins, passes through the venous network under the placenta, and travels through the myometrial, uterine, ovarian, and internal iliac veins, the inferior vena cava, thence to the right atrium and ventricle. If the quantity of air is sufficient, death occurs.

A safe method of insufflating air into the vagina consists of first inserting a bivalve speculum and then insufflating around the cervical os, but not into it. The speculum is then rotated while powder is insufflated along the vagina. Thousands of powder insufflations, many during pregnancy, have been done by this method without undesirable side effects.

Some authors have listed pregnancy as a contraindication for powder insufflations. In fact, most of the manufacturers of these powders so indicate in their literature. As some of the most troublesome cases of trichomoniasis and moniliasis are encountered during pregnancy, it would be unfortunate to deny these acutely uncomfortable patients the benefit of an effective therapeutic agent. Pregnancy is not a contraindication for vaginal insufflations if proper technique is used.

Most of the cases of air emoblism following douching for hygienic purposes reported occurred in pregnant women or shortly after the patient had completed a menstrual period. Forbes[24] had a case of a 34 year old woman who had three previous pregnancies. She complained of feeling poorly on June 30, 1943, but attributed her symptoms to the expected onset of her menses. She began to menstruate on July 1, 1943. The next day, at about 9:50 p.m., on her way to bed, she collapsed and died a short time later. No further details were available at the time and there was nothing to suggest the cause of death. At autopsy, 17 hours later, a blood stained perineal pad was noted, but external examination revealed nothing of importance. On opening the abdomen a retroverted, gravid, nonimpacted uterus was observed. The uterus was opened and the placenta was found to be low on the right lateral wall with its lower edge detached to a depth of one inch and the membranes were separated to a depth of 2½ inches. The right side of the heart was dilated and on opening it, the right atrium and ventricle were found to be filled with frothy blood; the pulmonary artery contained identical material. On the basis of the autopsy, a criminal abortion was suspected and further inquiries were made. It was discovered that the patient had taken a vaginal douche shortly before retiring and that death, resulting from air embolism, was accidental, the woman being totally in ignorance of her condition. Other such cases have been reported[25].

Killinger and Collins[26] report a case of a 40 year old quadripara in the seventh month of her fifth pregnancy, who was found dead in bed with a rubber catheter, to which was attached a dry douche bag by means of a connecting rubber tube. This was inserted tightly through the cervix. This airtight apparatus was apparently used to pump air through the cervix. Postmortem examination revealed a distended, crepitant uterus with all lacunae and uterine appendages filled with air. The placenta had been perforated by

the catheter and blown apart by a powerful air blast. The inferior vena cava and right side of the heart were distended with foam and blood. Air was found in the vessels of both lungs.

It has never been shown that the knee-chest position has any value whatsoever in the immediate puerperium. Still it is illustrated in many pamphlets on postpartum exercises. As several fatalities have been reported following this position, and we are about to add another one to the literature, we cannot stress too strongly that this position should be avoided.

Quigley and Gaspar[27] reported a fatal case in a 26 year old primipara. She had delivered spontaneously and had an afebrile postpartum course. On the eighth day postpartum, after being in the knee-chest position for five minutes, she suddenly collapsed and died. She had done the knee-chest exercise twice for 30 minutes the day previous to her death. An autopsy four hours after death revealed a moderately subinvoluted uterus containing small fragments of retained placental tissue with surrounding hemorrhages and blood clots. The right ovarian plexus, inferior vena cava, and right heart were distended with frothy blood.

Stroth and Ohlinger[28] report a case of a 39 year old multipara who had a normal spontaneous delivery and an uneventful puerperium. On the seventh day, after assuming the knee-chest position for the first time, she suddenly collapsed and died within five minutes. Autopsy revealed extensive air embolism of the right ovarian vein, inferior vena cava, and right heart.

Redfield and Bodine[9] reported two similar cases and compared the mechanism of air embolism to that of a bellows. A woman in the knee-chest position, having the labia separated, permits an inflow of air to the vagina and, in some cases, the uterus. When she decends from this position, the labia close and, with the collapse of the vaginal walls and the uterus, air is forced into the open uterine sinuses. Retained placental tissue and failure of involution are predisposing factors.

The following case occurred in 1954.

Mrs. D.M.E., white, aged 23. This woman had delivered spontaneously, without anesthesia, a 7 pound 6¼ ounce living female after an uneventful pregnancy on Sept. 27, 1952. Her only minor complaint during pregnancy was the appearance of bilateral popliteal varices. Her puerperium was normal.

She began her antenatal visits for this last pregnancy on Jan. 27, 1954 at which time she was approximately three months pregnant. Her last period had occurred on Oct. 14, 1953. At her first visit she had had no unusual symptoms thus far other than occasional nausea and vomiting, frequency, nocturia, breast swelling, and a mucoid leucorrhea. The family history was essentially negative. There were no past illnesses of any significance and no previous surgery. Physical examination revealed a small umbilical hernia and bilateral saphenous varicosities; all other findings were normal. External and internal mensuration revealed a gynecoid pelvis. The perineum was slightly relaxed and there was bilateral notching of the cervix with a mild endocervicitis. Blood pressure 106/70; Hgb. 80%; urine negative; Kahn negative; Rh factor positive; weight 149 lbs.

The patient reported faithfully for her prenatal visits and the pregnancy proceeded uneventfully. She gained 20 pounds and had no variations from normal in her urine and blood pressure. Her hemoglobin dropped to 76% in the sixth month.

On July 15, 1954 her membranes ruptured spontaneously and labor commenced. She entered the hospital 55 minutes later. The first stage of labor was rather desultory and only after 14 hours of mild labor did the patient spontaneously deliver a 6 pound 14½ ounce living female without anesthesia. Episiotomy was not performed and there were no cervical or perineal lacerations. The placenta was expressed by simple Crede and appeared intact. Blood loss for the entire procedure was approximated at 50 cc. Mother and infant left the delivery room in excellent condition and fared well thereafter.

During the patient's five day stay in the hospital there was no elevation of temperature, pulse, or blood pressure. Lochia was scant. The patient elected to breastfeed her infant. She became ambulatory on her first postpartum day and had no complaints whatsoever during her entire stay. Two days after discharge she was readmitted to the hospital per ambulance but was pronounced dead on arrival. There was no external evidence of the cause of death.

When past events were reconstructed, it became evident that the woman had entered the bedroom while her husband was in the next room and had begun her postpartum exercises by assuming the knee-chest position. When he entered the room several minutes later after hearing a sigh, he found her pulseless, apneic, and cyanotic.

Autopsy, performed three hours after death, revealed a right atrium and ventricle which were distended with a foamy mass of blood and air bubbles. The inferior vena cava contained frothy blood. The uterus was enlarged, soft, and boggy. The endometrial surfaces were hemorrhagic and adherent to the posterior wall of the uterine cavity was a small, shaggy blood clot. Sections through the wall of the uterus revealed multiple dilated venous channels. No retained placental tissue could be found.

It became apparent from this postmortem examina-

tion that the large venous sinuses at the placental site, even though capped by thrombus, may be open as late as seven days following delivery and may allow the entrance of air into the venous circulation if the circumstances are proper.

For years before this incident we had routinely, and I am sure without thinking too much about it, instructed our puerperal patients in the use of the knee-chest position after arrival at home. Suffice it to say that we have banned the use of this exercise during the puerperium since 1954.

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Malnutrition and immune-body reactions

Malnourished children appear to have poor resistance to infection. In order to determine whether this is due to impaired antibody production, the isohemagglutin in titers of 14 severely malnourished children were examined. These titers were within normal limits. This seems to confirm findings of other authors that in man, unlike laboratory animals, malnutrition does not impair immune-body reactions. *E. Kahn, M.D. et al. Isohemagglutinins and Immunity in Malnutrition. Am. J. Clin. Nut. Jan.-Feb.* 1957.

The Management of the Intersex Patient

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A person's sex is the most profound and fundamental biologic fact concerning his life. No other physical or bodily attribute has as much influence in determining his orientation, social status, and activities. No other personal fact is antecedent to it in importance.

The basic importance of determination of sex usually is unnoticed because, as a rule, there is no uncertainty, and the person's sex is fixed at the time of birth. It is only when there is some question as to the true sex that the fundamental importance of proper determination becomes apparent.

The group of persons of uncertain sex is under discussion. Since ancient times they have been known as hermaphrodites, although recently the more descriptive and accurate term, intersex, gradually is supplanting the older term. Within the last 20 years there have been important additions to our knowledge of these states and our understanding of diagnosis and treatment.

First, we may define an intersex as an individual whose sex is not completely certain. In other words, if any clinical features bring the nature of the individual's sex into question, then that individual should be classified as an intersex.

Intersexes usually are divided into two groups: A primary group in which the basic gonadal and secondary sex pattern is intrinsically abnormal; and a secondary group in which sexual development is altered by some extra gonadal force, usually hormonal. The first group comprises individuals who are still known as hermaphrodites and is divided into three subgroups: so-called true hermaphrodites, having gonads of both sexes; so-called male pseudohermaphrodites, having male gonads but some feminine characteristics; and the female pseudohermaphrodites, having female gonads but some male characteristics. The secondary intersexes are those with so-called adrenogenital syndrome.

The clinical basis of this paper is a series of 44 intersex patients seen at the Research and Educational Hospitals and Clinics of the University of Illinois Medical School. The study and care of these patients has always been a cooperative project involving many people who have all worked together in their study and treatment. The total number of patients is divided into groups as follows:

True Hermaphrodites	5
Male Pseudohermaphrodites	11
Female Pseudohermaphrodites	0
Adrenogenital Syndrome	
—Females	22
— Males	* 9
Gonadal Dysgenesis	5
Testicular Hypoplasia	1
Total Intersex	44

*Not intersex.

At this point we should try to define as clearly and accurately as possible in our own minds what sex is. This is not an easy question to answer and in some ways, is almost a philosophical as well as a medical question. I think we can best approach it by reviewing first what attributes or features determine sex and, after examining these traits, try to evolve a definition of sex.

The first and most basic feature that determines sex is the chromosomal pattern of the individual's cells. Depending on the kind of sperm uniting with the ovum at fertilization, the resulting individual carries XX (female) or XY (male) sex chromosomes in all its cells.

Presented by the senior author as the presidential address to the Chicago Urological Society, April 26, 1956

Up until recently, it was thought that the individual's clinical sex always corresponded to the chromosomal sex. Recent evidence discussed later, indicates that this is not always so.

The next most important factor that determines sex is the nature of the gonads. For many years, this was considered the best indicator of the true sex, but is now found unreliable.

The next factor is the hormonal pattern. The hormonal effect on the growth and development of tissues and organs is one of the mechanisms by which the gonads regulate and influence sexual development. However, we find that hormones from extragonadal sources also can drastically alter the development of sex features.

The most obvious group of factors determining clinical sex are the sex organs, including the internal and external genitalia and the secondary sex characteristics.

Another factor determining sex is the psychic pattern. This is influenced by the hormonal pattern as well as by the upbringing and experience of the individual, but is an uncertain guide as to true sex.

After considering these factors, we are in a little better position to define sex as follows: Sex is the overall state of body and mind by which the individual conforms to the male or the female standards of normality in the named sex-determining factors. It is an algebraic summation of these factors in which no one factor supersedes the others. In other words there is no single conclusive determining factor. Every individual we know is a mixture of characteristics of the male and female, and it is the algebraic sum or preponderance of all these factors that determines sex, and not any one of them.

How is sex determined in the individual? We may consider the determining factors in two groups. First, the entirely genetic factors that are part of the patient's makeup or inheritance and then a second group, the later influences which may come to bear on this development.

Among the inherited factors, we have the chromosomal pattern above mentioned. It is either XX or XY (although some have postulated an abnormal XXY chromosome). The nature of the gonads is apparently governed by genes as to whether the indeterminate gonad will differentiate to testes or ovaries. The genetic hormonal pattern, to some extent, is governed by genes that govern development of the pituitary gland, the gonads, and the adrenal cortices and their relative hormonal output. The development of the other sex organs also is determined by a genetic pattern as to their basic capability for development. The chromosomal pattern cannot be changed.

The possibility of the nature of the gonads being altered by influences acting during the developmental stage has been brought out by experimental work in animals and insects. Hormonal pattern may be readily altered during development and even at later times during life.

Development of the normal sex organs and characteristics may be altered by external influences such as roentgen effects on gonads or on individual organs like the breast; also by disease states such as mumps. Later influences acting on the psychic pattern are important; the upbringing of individuals can strongly influence their psychosexual pattern and even entirely alter it.

Clinical determination of sex should be done as early in life as possible. This would seem to be axiomatic, yet not everyone agrees with this idea.

"Change of sex" is always difficult and becomes progressively more so as the patient gets older. Where "change of sex" is necessary, the person will adapt satisfactorily to the assigned sex if the change is effected early in life. Of all medical problems, this is one in which an objective viewpoint is necessary; preferably the collective consideration and opinion of a group with special knowledge of the factors in this type of case. The subjective opinion of the patient, who has no knowledge whatever of the many and complicated factors concerned, should not be the criterion.

After this theoretical discussion we come down to the practical points of the clinical determination of the previously mentioned factors. Upon these, the final determination of the individual's sex will be made.

The chromosomal pattern can now be detected quite accurately by study of the sex chromosomal pattern. This method was discovered by Dr. Murray L. Barr, of the University of Western Ontario, about 1950. His method has been used by Dr. Elizabeth McGrew, at the University of Illinois with excellent results. More recently,

mouth scrapings have been used and it seems that this method is just as accurate as the skin biopsy. A group in England (Davidson et al.) has studied blood smears and they have detected a sexual difference in the nuclear pattern of the neutrophil leucocytes.

The exact nature of the gonads can be determined only by biopsy and where there is any question, exploration to expose them and histologic section of biopsy specimens should be done.

Chemical determination of the hormonal pattern is helpful in some cases, particularly those of the adrenogenital syndrome, in which determination of the 17-keto-steroids is most important. The determination of pregnanediol excretion also is helpful. Urinary androgen and estrogen levels and gonadotropin levels are not nearly so helpful but may be done occasionally.

Examination of the genitalia must be carefully and thoroughly done. The size and shape of the phallus is not decisive, and an enlarged clitoris and a small hypospadic penis may be indistinguishable. The presence of a vagina or uterovaginal complex may be detected by examination with the cystoscope and if necessary by radiography, injecting the vaginal and uterine cavities. Intraperitoneal air insufflation also has been suggested. We have not made use of this procedure. Determination of the exact nature of the internal genitalia usually requires abdominal exploration by laparotomy at which time biopsy of the gonads can be done.

The psychic pattern of the individual can be more accurately evaluated by persons trained in this work. It is difficult in infancy and early childhood. Roentgen examination of the sella turcica and epiphyseal areas is always done. Retroperitoneal air insufflation is rarely necessary now. Levels of the blood electrolytes also are determined and are especially important if there is evidence of the salt-losing syndrome.

The final assignment of sex in any given individual is made only after group consideration of all the factors determined by the above mentioned procedures. It is impossible to assign a fixed table of relative values to the various factors.

The genitalia and secondary sex characteristics are not of primary biologic importance but we must remember that their character and development, especially of the copulatory organs, govern the potential adaptability of the individual to one or the other sex. Therefore, they assume a practical importance far above their biologic importance.

The chromosomal pattern is the most recent to be used and is in a sense the most basic factor biologically. Still, it is not an entirely true guide in itself, as we see in those groups previously mentioned of gonadal dysgenesis and testicular hypoplasia.

The final sex for the individual usually will be that which fits the gonadal, chromosomal, and genital sex patterns best. In some cases, including true hermaphrodites, where the genital organs also are indeterminate, the final decision will be most heavily influenced by the potential adaptability of the sex organs to the normal pattern of the sex selected. This may be true even though it does not entirely agree with other factors.

The corrective procedures are of two kinds: medical and social. The medical procedures aim at factors that are at variance with the normal pattern for the assigned or established sex. No special social measures are necessary if there is no change of sex. All efforts should be inconspicuous; usually encouragement of normal childhood activities such as those at school, scouts, and games will suffice.

Change of sex has been required in eight cases in our series. It is, as previously mentioned, best done in infancy as the attendant difficulties increase progressively with the individual's age.

The adrenogenital syndrome is the largest single group. It is not uncommonly familae. Clinically, it appears more often in females, although there may be some error here due to the fact that the milder cases in boys could escape diagnosis. There frequently is error in sex diagnosis at birth requiring later change of sex.

The establishment of the chromosomal pattern by skin biopsy and of the characteristic hormonal picture of increased 17-keto-steroid output is almost diagnostic. Therapeutic trial of medical treatment with cortisone usually confirms the diagnosis.

In the last few years the discovery that some of these patients also have electrolyte disturbances has added another important and complicated element to the clinical picture. Apparently the hyperplasia of the steroid forming elements

in some way alters the electrolyte-controlling hormone output so that there is sodium loss and retention of potassium. This may lead to a clinical picture of shock, vomiting, and dehydration, placing these patients, especially young infants, in a critical state. The changes can be confirmed by chemical determination of the sodium and potassium levels in the serum.

In 1950 Wilkins first reported the use of cortisone in the treatment of adrenal hyperplasia and this mode of treatment is now standard. Cortisone in these cases depresses the pituitary adrenocortical stimulating hormones, and as far as we can tell up to now, allows near normal growth and development of these children.

The adjuvant therapy consists of surgical clitoredectomy and vulvoplasty and this usually is done at once or soon after the age of one year. In males with adrenogenital syndrome, cortisone only is used. No corrective surgery is necessary.

If the adrenogential syndrome is accompanied by electrolyte disturbance, there is danger to life. Cortisone therapy here also corrects the electrolyte disturbance, supplemented at first by desoxycorticosterone acetate administration until the electrolyte levels are brought to more normal range. The long acting Percorten (desoxycorticosterone triurethyl acetate) was first used by our group in these children.

In adenogenital syndrome due to tumor, surgical removal of the tumor is the only proper course. Presacral retroperitoneal air insufflation is a helpful procedure in these cases in making an exact diagnosis of adrenal tumor as well as the lack of drop in hormone output with cortisone therapy. We have had one such case with complete recovery following removal of the tumor.

We should mention here that a few cases have been reported in which there apparently is adrenocortical hyperplasia with electrolyte disturbance but without the adrenogenital syndrome. In other words, the hormones produced are not androgenic so that no sexual effects of importance are noted. In these cases, hormonal treatment as above described corrects the electrolyte disturbance and is adequate treatment.

The next largest group is the so-called male pseudohermaphrodites. Here also there has been frequent error in determination of sex at birth. Many of these patients with hypospadias and undescended testes were thought to be females and were raised as such. Included in this group are individuals varying from those with a distinctly male habitus and hypospadias all the way to cases with a female habitus, gynecomastia, a rudimentary penis, and an almost normal size vagina. Differential diagnosis must be made between this group and so-called true hermaphrodites. Most male pseudohermaphrodites have a male gonadal and psychic pattern and usually prefer to be male. Their hormonal pattern is of the male type and correction of the situation involves repair of hypospadias, orchiopexy and, in some cases, mastectomy.

Female pseudohermaphroditism of the non-adrenal type is the smallest group of all. It is unusual to find a primary intersex with ovaries and we have not seen such a case. Assignment of sex in such cases depends on the adaptability of the secondary sex organs and the correction necessary to adapt them to the assigned sex, which usually is female.

The most interesting group historically is that of the true hermaphrodites. We have had five such cases in our series. This subject has always been of exceptional interest and about 60 reported cases have now been well documented. By definition these individuals have both testicular and ovarian tissue. No case on record has ever had functioning of both testis and ovary so as to form both fertile sperm and ova. As a matter of fact, most intersex cases of all kinds are sterile. The diagnosic problem is to determine the sex into which the patient best fits by the criteria mentioned. The established sex may or may not be in accord with the chromsomal pattern or with the apparent major gonadal element. The secondary sex characters must be taken into consideration in considering the adaptability to the assigned sex. Surgical correction can be carried out satisfactorily in nearly all cases.

The condition now called gonadal dysgenesis was known formerly as ovarian agenesis, or Turner's syndrome. The patients have completely undeveloped gonads and the genitalia and secondary sex characteristics are infantile female. Recent sex chromosome studies reveal that most of them have a male chromosomal pattern; however, in the absence of any male gonad the

female genital pattern develops, apparently by default. We are in the process of checking our cases now and have found a male pattern in a couple so far. This does not alter the clinical handling of these cases; they should continue as females, with hormone therapy to assist to this end.

The group most recently added to the intersex fold are those with testicular hypoplasia. These patients present a clinical picture of gynecomastia and aspermatogenesis but normal Leydig cell development. The second case with hormonal studies was reported by Dr. Bronstein of our group in 1939. In 1942 Klinefelter with others reported nine cases and his name has since been connected with it. Within recent months Dr. Barr has shown that some of these patients have a female chromosomal pattern and we have had one patient in whom this pattern has been found. We are trying to get older patients back for re-check.

SUMMARY

Wherever there is question as to true sex, a thorough and comprehensive study should be made without delay to determine as accurately as possible the status of the patient with reference to the sex determining factors:

(1) Chromosomal pattern
(2) Gonadal type
(3) Hormonal pattern
(4) Sex organ development
(5) Psychic pattern

On the basis of these findings the patient's sex should be established and medical, surgical, and social corrective measures instituted. This will allow the patient to develop normally or very near normally, physically, socially, and psychically, and will prevent the lifetime maladjustments and tragedies that fill the historical works on the subject.

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The Second Hundred Years

G. Howard Gowen, M.D., Springfield

THERE has been improvement in life expectancy at birth in the United States (all races and both sexes) from 47.3 years in 1900 to 68.6 years in 1952.[1] Concomitantly, those 65 years and over now form a larger per cent of the total population. Their future, however, in terms of average remaining lifetime in years has not markedly improved since 1900.[2] It is doubtful if there will be significant a change in life expectancy at 65 and over until the research laboratories have provided methods to combat the inroads of illness such as cardiovascular disease, cancer, and vascular lesions affecting the central nervous system. The efforts of science have never been more intense nor better directed, and it is reasonable to expect that some of the answers will be found in the foreseeable future. Once this has happened, a sizable number of persons should begin to break the 100 year age barrier. It is the purpose of this paper to make certain observations about residents of Illinois who lived into their second century. Since morbidity figures are not available, death statistics will have to be used for this purpose.

Table 1 shows the number of deaths in the age group 100 years and over from 1921 through 1955.[3] There are fluctuations from year to year, and the slight upward trend could be accounted for by the gradual increase in total population. It is apparent that more females live into their second century than males.

Table 2 gives a more detailed breakdown of the deaths in 1955.[3] Of those who live to be 100 or more, only a few survive beyond 104 years. The predominance of the female is again emphasized.

Table 3 gives the causes of death as reported on the death certificate.[3] Persons living to be 100 years of age and over are having their lives terminated principally by cardiovascular disease, arteriosclerosis in particular. How long they could have lived were it possible to prevent arteriosclerosis is a moot question. The potentialities, however, are apparent. Table 4 was pre-

TABLE 1
DEATHS OF PERSONS 100 YEARS OF AGE AND OVER: ILLINOIS, 1921-1955

YEAR	TOTAL	Male	Female
1955*	68	20	48
1954*	42	9	33
1953*	71	20	51
1952*	46	11	35
1951*	45	17	28
1950*	62	22	40
1949*	52	18	34
1948*	44	18	26
1947*	42	15	27
1946*	44	11	33
1945*	50	22	28
1944*	32	13	19
1943*	47	14	33
1942*	41	13	28
1941*	42	19	23
1940*	37	17	20
1939**	31	12	19
1938**	46	21	25
1937**	33	9	24
1936**	48	20	28
1935**	49	21	28
1934**	38	10	28
1933**	31	11	20
1932**	40	15	25
1931**	42	16	26
1930**	42	18	24
1929**	43	14	29
1928**	48	12	36
1927**	34	15	19
1926**	49	20	29
1925**	50	21	29
1924**	35	17	18
1923**	49	24	25
1922**	43	9	34
1921**	33	14	19

*Deaths of Illinois Residents Including Those Dying Outside The State.

**All Deaths Occurring Within Illinois, Irrespective Of The Decedent's Usual State Of Residence.

SOURCE: Bureau of Statistics, Illinois Department Of Public Health, Springfield, Illinois, Unpublished Data.

Deputy Director, Division of Hospitals and Chronic Illness, Illinois Department of Public Health, Springfield.

TABLE 2
DEATHS AMONG ILLINOIS RESIDENTS OF PERSONS 100 YEARS OF AGE AND OVER; BY AGE AND SEX: 1955

AGE	TOTAL	SEX	
		Male	Female
100 years	28	8	20
101 years	14	4	10
102 years	10	4	6
103 years	3	1	2
104 years	6	1	5
105 years	1	–	1
106 years	1	1	–
107 years	1	–	1
108 years	1	1	–
109 years	1	–	1
111 years	1	–	1
112 years	1	–	1
Total 100 plus	68	20	48

SOURCE: Bureau of Statistics, Illinois Department of Public Health, Springfield, Illinois, Unpublished Data.

pared to compare the leading causes of death 100 years and over with those of all residents. The only notable difference is that in the group

TABLE 4
LEADING CAUSES OF DEATH: ILLINOIS, 1955

All Age Groups	*100 Years and Over*
1. Heart Disease	1. Heart Disease
2. Cancer	2. Vascular lesions affecting central nervous system
3. Vascular lesions affecting central nervous system	3. Pneumonia and influenza
4. All accidents	4. Miscellaneous (one each)
	a. Accident
	b. Cancer
	c. Senility
	d. Gastro-enteritis and colitis

SOURCE: Bureau of Statistics, Illinois Department of Public Health, Springfield, Illinois, Unpublished Data.

100 years and over, vascular lesions affecting the central nervous system have replaced cancer as the second most important cause of death.

To attempt to obtain other information about the age group under discussion, a study was

TABLE 3
CAUSES OF DEATH AMONG ILLINOIS RESIDENTS OF 100 YEARS OF AGE AND OVER—1955

Cause	International List Number*	Total	Sex	
			Male	Female
Cancer of Large Intestine	153.0	1	1	–
Cerebral Hemorrhage	331.0	7	2	5
Cerebral Embolism & Thrombosis	332.0	3	–	3
Arteriosclerotic Heart Disease	420.0	18	5	13
	420.1	9	5	4
Chronic Endocarditis	421.4	1	1	–
Other Myocardial Degeneration	422.1	5	1	4
	422.2	5	3	2
Acute Myocarditis not Rheumatic	431.0	1	–	1
Other Diseases of Heart	434.3	2	1	1
Hypertensive Disease	442.0	1	–	1
	446.0	2	1	1
General Arteriosclerosis	450.0	4	–	4
	450.1	1	–	1
Influenza without Pneumonia	481.0	1	–	1
Bronchopneumonia	491.0	4	–	4
Gastro-Enteritis & Colitis	571.1	1	–	1
Senility Without Psychosis	794.0	1	–	1
Fall	903.0	1	–	1
		—	—	—
All Causes		68	20	48

*From International Statistical Classification of Diseases, Injuries, and Causes of Death (Sixth Revision, 1948), World Health Organization.

SOURCE: Bureau of Statistics, Illinois Department of Public Health, Springfield, Illinois, Unpublished Data.

made of the death certificates of those dying in 1955. Thirty-three were residents of Chicago and Cook County, and an almost equal number were residents of downstate Illinois. Analyzing the deaths by county it was found that they were widely distributed throughout the State with heaviest concentrations in Adams County and St. Clair County, three in the former and four in the latter. When consideration is given to the fact that the population of St. Clair County is slightly more than three times the population of Adams County, the three deaths in Adams County become more meaningful. Also, it is known that in Adams County the population 65 years and over composes a greater percentage of the total population than is true of Illinois as a whole.

The following table shows where these deaths occurred:

	Own Home	Nursing Home	Hospital
State total	42	14	11
Chicago and Cook County	18	9	6
Downstate	24	5	5

Most of these centenarians were in their own homes at the time of death, which is probably not what would commonly be expected. The pattern is not materially different between the Chicago area and downstate, although in the latter there was a greater tendency to keep the older person at home.

SUMMARY

1. From 1921 through 1955 in Illinois, 1,549 persons reached 100 years before dying. Of these, 558 were males and 991 were females.
2. Cardiovascular disease was largely responsible for the deaths occurring in this age group during 1955.
3. Of those who died in 1955 more than 60 per cent were living in their own homes at the time of death. The deaths were widely scattered throughout the State and the number who were residents of Chicago and Cook County were practically equal to those living downstate.
4. During the 35 year period from 1921 through 1955, there has been no change in the number of persons reaching 100 years of age that could not be accounted for on the basis of general population increase.

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Who's cooking?

"I always have an upset when we eat at my mother-in-law's. There's something about the way she cooks—no matter what it is—that just doesn't agree with me.

"I wouldn't want to go to Europe and besides, the food would make me sick.

"Aren't you afraid to take your kids to Florida? They will probably get sick from the strange food."

Such remarks are commonplace and not only in our society. *Harriett Bruce Moore. The Meaning of Food. Am. J. Clin. Nut. Jan.-Feb. 1957.*

The Problems of Ulcerative Colitis — A Blueprint for Research in Gastroenterology

Joseph B. Kirsner, Professor of Medicine, University of Chicago

Doctor Samter: The gastrointestinal tract has always furnished us with interesting topics for discussion because so many of its diseases are multiple-factor diseases. Infections, allergies, emotional disorders, endocrine regulations appear to cooperate in its difficulties and emphasize the need for a rigid differential-diagnostic approach. We are happy to welcome Doctor Joseph B. Kirsner, Professor of Medicine at the University of Chicago and President of the Chicago Society of Internal Medicine, to our Seminar. As you all know, Doctor Kirsner has done extensive investigative work on the problems of ulcerative colitis.

Doctor Kirsner: Thank you, Doctor Samter. It is true that the study of ulcerative colitis combines several disciplines at both clinical and basic levels. I shall outline some of the clinical, therapeutic and pathologic aspects of ulcerative colitis, with reference to its development and course and also describe some of our studies concerning this mysterious disease. In doing this, I am well aware of the fact that I shall present you with questions rather than with answers.

Ulcerative colitis is both an acute and a chronic ulcerative disease. Proctoscopy usually demonstrates diffuse inflammation, small erosions and ulcerations, intense hyperemia and congestion. There may be severe necrosis of the bowel wall, especially involving the mucosa and submucosa; not infrequently only small islands of mucosal tissue remain; yet the potential for healing is great and striking regeneration of the bowel wall may be observed.

Ulcerative colitis is commonly thought to be a disease of young adults, between the ages of twenty to forty. However, it occurs at all ages —in children as well as adults. During the past year, I have seen a number of very young patients with rather extensive colitis. The relatively young age of onset perhaps represents a clue as to pathogenesis, possibly reflecting hyper-reactivity of the colonic tissue or some factor increasing the susceptibility to the disease. On the other hand, ulcerative colitis occasionally begins in individuals over the age of 60, so that the age factor may not be too significant.

In 50 percent of cases, the entire colon is involved; and in the remainder varying portions of the bowel are affected; most often the rectum, sigmoid and descending colon. In some instances, there is no x-ray evidence of the disease, though the proctoscopic changes are unequivocal. Ulcerative colitis is typically a chronic and recurrent illness. The mortality rate seems to be highest during the first one or two years of illness. Subsequently the disease may persist for many years.

The course of ulcerative colitis is quite variable. In perhaps 50 to 60 percent of cases, in our experience, the initial bowel involvement, as demonstrated by x-rays, remains the only or the maximal involvement throughout the patients' illness. In a small number of patients the disease begins in the rectum and progresses relentlessly to involve the entire colon. In other instances there may be improvement in the roent-

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gen appearance of the colon, with reversibility towards normal.

The numerous complications include polyp formation, carcinoma, hemorrhage, giant ulcerations, perforation and peritonitis, strictures and obstruction, fistulae and abscess formation, electrolyte depletion, impaired absorption and a variety of systemic effects. Carcinomatous changes may occur in 3 percent of cases, definitely higher than the incidence of carcinoma of the colon in the general population. The figures will depend to some extent on the type of material under study, whether it be clinical, surgical, or obtained on autopsy. Systemic complications include anemia, nutritional deficiency, pyoderma gangrenosum, arthritis, vascular thrombosis, iritis, erythema nodosum, hepatitis, fatty or degenerative changes, or cirrhosis of the liver, pancreatitis, glomerulitis, and adrenal insufficiency. Perforation and peritonitis are the principal causes of death; followed by hemorrhage, carcinoma, vascular thromboses, pneumonia, malnutrition, electrolyte and fluid depletion.

The medical treatment of ulcerative colitis is symptomatic, individualized and prolonged. In a practical sense, this means understanding, infinite patience, rest, elimination of infection, proper nutrition, psychotherapy and hormonal therapy. Steroid therapy, although not curative, is quite helpful. In a series of 180 unselected cases, steroids induced remissions in 164. 115 cases relapsed when the dose was reduced or the medication discontinued, but with retreatment, steroids induced remission in 85 cases. The prolonged use of steroids in many patients with ulceratice colitis seems to be useful; the incidence of complications, in our experience, has been remarkably low.

What then are the prospects of treatment? Medical treatment is effective in approximately 80 percent of cases; despite relapses and remissions, patients are able to lead useful lives. Surgical treatment with total coleetomy and ileostomy is indicated in approximately 10 percent of cases. The course in 5 percent is uncertain; some of these patients eventually require surgery. The mortality rate at present is 5 percent. Evaluation of the need for surgery may be very difficult: I recall one case of severe ulcerative colitis seen in 1934 scheduled for ileostomy, which was deferred because of a respiratory infection. The operation was never performed and the patient has been in good health for many years. In our opinion, merely putting the colon at rest with a surgical ileostomy does not cure ulcerative colitis.

Innumerable bacterial agents have been suggested as etiologically significant; however, none has been established conclusively. Although bacterial counts on the feces of patients are increased, the identifiable bacteriologic pattern of the feces in ulcerative colitis does not differ from the normal. The role of viruses is yet to be fully studied; they have been implicated in certain enteric infections and may prove to be of some importance in ulcerative colitis.

Many other possible etiologic factors have been considered. Emotional disturbances may cause hyperfunction of the colon; this observation together with the anatomic finding of increased numbers of nerve ganglia in the bowel wall of patients with ulcerative colitis emphasize the role of psychogenic factors. There is a high incidence of emotional disorders in patients with ulcerative colitis. Whatever the psychogenic mechanisms, emotional factors are important at some level of the disease and must be carefully considered in the practical management of the patient. In many cases the onset of the disease appears to be associated with psychic trauma; recurrences are commonly related to episodes of stress and nervous tension. The psychogenic aspects of ulcerative colitis present many unsolved problems: psychosomatic versus somatopsychic factors; the specificity of the emotional disorders; the apparent infrequency of ulcerative colitis after "irritable bowel" syndromes. Controlled studies are urgently needed in further evaluating this problem.

There have been relatively few attempts to produce colitis experimentally in animals. "Colitis" apparently has been produced by deficiencies of Vitamin A and folic acid, mesenteric lymphatic obstruction, administration of histamine and lysozyme and by the injection of cholinergic drugs such as acetylcholine, doryl, mecholyl and prostigmine. In our laboratory, intestinal hypermotility has been induced in dogs by various cholinergic drugs. Continued administration of doryl and mecholyl produced a hyperemic, friable, granular mucosa, not unlike that seen in the human disease; in some dogs, the mecholyl was continued for periods

up to 770 days; yet, when the drug was discontinued, the bowel quickly reverted to normal. It has been suggested that emotional disturbances might facilitate the release of destructive proteolytic enzymes. Thus, the injection of melysozyme in colonic pouches of dogs; and increased amounts of lysozyme are present in the feces of patients with active ulcerative colitis. However, similar concentrations of lysozyme may be induced in dogs, in the absence of ulcerative colitis, by electrocoagulation of the rectum. There is no conclusive evidence that lysozyme or similar compounds are of primary etiologic importance in ulcerative colitis; however, they may contribute secondarily to the process.

The serum mucoprotein levels are increased in ulcerative colitis. However, similar increases in neoplasms, chronic infectious diseases, as well as in collagen diseases, suggest that the serum mucoproteins, like numerous other tissue reactants, merely reflect tissue injury.

Another channel of investigation concerns the association of ulcerative colitis with other diseases, such as glomerulonephritis, hay fever, disseminated lupus erythematosus, periarteritis nodosa, rheumatic fever, rheumatoid arthritis and scleroderma—all so-called "connective tissue diseases;" however, the relationship may be entirely coincidental.

In recent years, we have investigated the frequency of carcinoma of the bowel in ulcerative colitis by the technique of exfoliative cytology. The mucosa appears to react to active inflammation by shedding a characteristic cell, which we have called the "large bland cell." Follow-up studies on several patients since 1954 have convinced us that this atypical cell is evidence of chronic inflammation rather than of carcinoma.

Other studies have demonstrated that the homogeneous ground substance of the connective tissue of the rectum and colon is disorganized and the basement membrane is disrupted in active ulcerative colitis. The exact significance of this observation is yet to be ascertained. Similar changes may be noted in the region of polyps and cancer of the colon, but they seem to be much more frequent and more severe in active ulcerative colitis. It is interesting that ACTH may reverse these changes.

Does the pathology of ulcerative colitis give a clue to etiology? Grossly, there is hyperemia, hemorrhage, ulceration and inflammation of the bowel wall. The histologic findings include ulceration, infiltration with chronic inflammatory cells, cryptitis, fibrosis, atypical gland formation, giant cell formation or granulomas, polyp formation, and rarely, vasculitis.

In summary, the suggested causes of ulcerative colitis include allergy, hypersensitivity phenomena, "collagen disease," deficiency states, enzymatic, infectious, neurogenic and psychogenic factors; unfortunately, the fundamental cause is yet to be determined.

Doctor Victor E. Pollak, Instructor in Medicine: One wonders whether the psychogenic factors which are apparent in ulcerative colitis are really different from those that accompany other forms of colitis? I was, of course, interested in your comments on renal tubular lesions which occur in ulcerative colitis: do you consider these specific lesions or do you feel that they represent secondary findings perhaps due to hypokalemia?

Doctor Kirsner: I am not aware of the existence of well controlled studies of the role of psychogenic factors in ulcerative colitis; I think such a controlled study would be difficult to design, but it certainly should be attempted. I do not regard the renal lesions found in patients with ulcerative colitis as representing a single specific entity; pyelonephritis is not uncommon; hypokalemia could be a factor in some instances.

Doctor Walter S. Wood, Instructor in Medicine: Would you elaborate on the relationships between polyp formation and carcinoma in ulcerative colitis?

Doctor Kirsner: The incidences of both polyps and carcinoma of the rectum and colon are increased in ulcerative colitis; and many observers have suggested a direct relationship between the two lesions. On the other hand, some investigators do not believe that the inflammatory pseudopolyps of ulcerative colitis are necessarily precancerous. Any focus of regenerative epithelial hyperplasia could conceivably progress to carcinoma. I think we would accept the higher incidence of carcinoma of the colon in this disease as very significant.

Doctor Wood: Would you comment on the incidence of perforation in the management of patients?

Doctor Kirsner: We have treated more than

200 patients with large doses of steroids without an increased incidence of perforation. Attention to supportive measures such as correction of nutritional deficiencies, prophylactic chemotherapy and careful observation in the hospital may have reduced the incidence of this complication in our series. It is well to remember not to give steroids when radiologically and clinically the bowel appears distended, since this finding probably indicates severe disease of the bowel wall and perhaps disruption of the muscular layers of the bowel.

Doctor John D. Blainey, Research Associate in Medicine: What is the relationship between the duration of the disease and the response to therapy?

Doctor Kirsner: Patients with mild or moderate disease respond more readily. Individuals with chronic severe colitis tend to respond slowly and to recur more frequently. I am inclined to the intensive management of the "early" case of ulcerative colitis, in the hope of a more complete therapeutic response and prevention of complication.

Doctor Blainey: What are your indications for surgery?

Doctor Kirsner: Our indications for surgery include uncontrollable hemorrhage from the colon, perforation, carcinoma (present or suspected), obstruction, and failure to respond to good medical management in the hospital. I am opposed to surgery on the basis of economic considerations or because of imcomplete response to incomplete medical management. Patience and perseverance are important ingredients of an adequate medical program for ulcerative colitis.

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Some Disorders of the Scalp

James Herbert Mitchell, M.D., Chicago

No paper on disorders of the scalp should begin without two quotations, neither one of which have I ever seen in print, but both of which I have been quoting over the years. The first of these is attributed to Sabouraud, who is supposed to have said that a bald head and a hairy chest are signs of virility. To young men showing unmistakable signs of the Hippocratic type of baldness this is the only consolation I have been able to give such men. They have frequently stuck out their hairy chests and agreed that I was probably right about that.

The second quotation is to the effect that if you would be the sort of person you would like to be you must first select your grandparents. This applies not only to the color of the hair, loss of color, and loss of hair itself, but especially to senile alopecia. Not being a Thomas — by the way, they are not of the "doubting Thomas" family as they know all about the scalp and hair —I recall with amusement a young man who had been referred to me by his aunt. Knowing the family and observing the unmistakable signs of premature alopecia I was obliged to tell the young man that he was destined to be bald; that he would have the typical Hippocratic type of baldness. A few days later the mother of the young man met my wife at an afternoon party of some kind—we will say a tea party, a euphemism for a cocktail party—whereupon the mother of the young man upbraided my wife roundly for my having, as she expressed it, "taken all hope away from her son." On my arrival home my wife was considerably upset by the way I had subjected her to such criticism. Some ten years later, however, the aunt died and we attended the memorial services. In the

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front row, sitting with the family, was a man with a perfect and complete Hippocratic type of baldness. On the way home I asked my wife who the young man was and she told me. I said, thereupon, I was not pleased to see that he was bald but that I was much pleased to see that my prognosis had been correct.

This happened during the depression at a time when I needed the fees but I did not need the money that much. Whereas the mother had criticized me for taking all hope from the young man, I strongly suspect that one of the advertising, hair growing quacks, took his money and left him as bald as I had prophesied he would be eventually.

Any competent dermatologist knows that the premature senile type of baldness begins in late adolescence and is fairly complete by the middle of the third decade, regardless of any visible change in the scalp. Innumerable times I heard Dr. Ormsby tell patients that they were destined to be bald and that unfortunately nothing could be done to save the hair. Nevertheless the advertising quack states in a quarter page ad that "One medical authority found local ailments responsible for 316 out of 320 cases of baldness and concluded that heredity is an insignificant factor."

I cannot multiply two by two and be sure of the result, but if one authority states that 316 cases of 320 cases were due to local ailments and later it is stated that local scalp disorders are considered responsible for up to 92% of all baldness, then 92% of 320 cases should be 294 cases instead of 316 cases.

It is amusing to follow the advertising of the quacks in which are shown the before and after pictures of their success in restoring hair in cases of alopecia areata. In this disorder, as we all know, the hair may regrow or not, as it sees fit, in complete disregard of any treatment the quacks may apply.

I am not going to discuss in detail the treatment of common baldness as Herbert Rattner in his Presidential Address at the meeting of the Chicago Dermatological Society in January 1941 gave us such a delightful paper which was as amusing as it was scholarly. I reread it recently with great pleasure and I urged Herbert Rattner to reread it himself. As the Editor of the Archives of Dermatology he begged off, saying that he had quite a little reading to do these days and that he would have to postpone a rereading of his own paper.

There is a common belief that circulatory disturbances of the scalp cause premature alopecia. Some years ago, because of a family connection, a young man fresh out of Harvard Medical School, and I mean fresh out of Harvard, was a guest of mine at the University Club for luncheon. He was quite sure of himself and without being aware of the fact that I was a dermatologist, told me that the cause of alopecia in men was due to their wearing hats that are too tight and the heads of these men are wedge-like. The old dictum that you can always tell a Harvard man, but you can't tell him much, applied very well to this young man. He was of the mensuration school and was confident he could predict by measurements who would have gallstones, appendicitis, diabetes, or kidney stones. We were lunching in the main dining room of the Club, the members of which are supposed to have college degrees. I called his attention to numerous bald pates with bulging brows of the Boston bean type and asked him to point out one bald head with the wedge-shaped type of skull. He surveyed the men and admitted he was unable to find one of the type he had described. Furthermore, I said that the last two patients I had seen before appearing at luncheon were twin boys, sons of a father who had typical Hippocratic complete baldness. The boys were on their way to entrain for the fall term of an eastern secondary school, and examination disclosed that at 18 they were candidates for their father's baldness. In a discussion of the etiology with the mother she informed me that neither boy had ever owned a hat.

Sabouraud says that to attribute calvities to a cap or to a dressing of the hair is another example of sophistry.[1] "Post hoc, ergo propter hoc." He also states (loc. cit.) that in ordinary baldness the younger the man the faster the progress. He states that although considered by the public a sign of precocious senility, it is not a disease of the aged but of the young, the very young. It is true there are many more bald old men than young men but once bald, always bald. Those who are bald young remain bald at 70.

In addition it is an established fact that common baldness is handed down through the male

line, although it may be transmitted through the female without that female showing any signs of baldness. Miller[2] calls attention to the possibility that baldness may be a generalized primate trait instead of a specifically human development and that it is forced upon man because it is one of the traits common to primates.

Over the years, when called upon to explain the cause of stasis dermatitis and leg ulcers I have told patients that when our ancestors got smart and began walking on their hind legs they doomed us to suffer from four disorders — namely, leg ulcers, inguinal hernia, low back pain, and interference with drainage of the sinuses. According to Miller, a fifth should be added — common baldness in the male.

Some years ago a young man in his middle 30's with a typical Hippocratic baldness consulted me about his loss of hair. He had been seen by many dermatologists in various parts of the middle west and was firmly convinced that the trouble was sluggish circulation in the scalp. Therefore, whenever he thought of it, which was apparently all the time, with both hands he pushed his scalp up and down at the sides. The result was that he had produced parallel wrinkles in the bald vertex, thereby making the baldness more conspicuous than it otherwise would have been.

In about this same decade — I have been at it so long I have ceased dating by the years, only by the decades — we attended a large dinner party and on the way home my wife told me her dinner partner regaled her all through dinner with the various efforts he had made to retain his hair. He had stood in line by the hour which formed all the way around a suburban block waiting to get his Sunday morning injection of pituitary hormone. Fortunately for my standing in the home I was the only dermatologist whom he had hadn't consulted. My wife was puzzled by the stupendous efforts he had exerted to keep his hair because, she commented, she was unable to comprehend how hair could improve his unattractive appearance.

The role played by seborrhea in baldness has always puzzled me. The term seborrhea was coined by Fuchs in 1840 and is a bastard word born of a Latin father and Greek mother. I have seen both men and women with marked seborrhea present for years with no alopecia and I have seen, as we all have seen, marked alopecia, especially of the Hippocratic type, with no seborrhea. Purdy[3] says, "The barber will tell you that you have seborrheic alopecia if your skin is greasy, but will blame a dry scalp if it is not."

Since puberty I have been bothered by marked seborrhea of the scalp and I keep trying to remember to mop my oily forehead, but notwithstanding I have been fortunate in keeping a fair share of hair.

Perhaps I was fortunate in having this seborrhea in that it was my introduction to a modern concept of allergy. As a Fellow in the Pathology Department under H. Gideon Wells I copied a formula found in Dr. James Nevins Hyde's textbook for the treatment of seborrhea of the scalp. The formula consisted of salicylic acid, resorcin, and sulfur in petrolatum, which I prepared in the laboratory. On a Sunday morning, in the dormitory, I shampooed my scalp thoroughly and applied the ointment. At breakfast that morning I ate strawberry preserves, given to the fraternity house by one of the fraternity mothers. By nighfall I was in misery, due to a universal pruritic toxic eruption. Having eaten fresh strawberries all my life I was loath to accept the eruption as due to preserved strawberries. By the end of the week the eruption had cleared, and cheered on by the fraternity brothers I determined to demonstrate whether or not the strawberry preserves had produced the eruption. Again, Sunday morning I ingested more strawberry preserves for breakfast. That evening I was worse than ever and I was about convinced, but to prove my contention I repeated the experiment for the third Sunday morning with much amusement to my fellow members. The result was terrific and I decided that I'd had enough and that would be the last of strawberry preserves for me.

However, the following Sunday night was by far the worst of all, and I decided to make a careful survey of the past few weeks. It occurred to me that the ointment might have had something to do with the eruption and therefore I prepared an ointment containing salicylic acid only, which was applied after the Sunday morning shampoo. Nothing happened. The following week I applied an ointment containing sulfur without any untoward result. The next Sunday

I applied an ointment containing resorcin, with frightful results. Some years later in practice I saw my first two patients with severe contact dermatitis due to resorcin contained in anusol suppositories.[4]

Over these many years I have repeatedly stated in discussions that I have been the only one present who did not accept without qualification what is meant by seborrheic dermatitis. I am much pleased to have the opportunity to read the paper by Purdy (loc. cit.) who has expressed views on this subject much better than I could have done.

In the various editions of Ormsby's "Diseases of the Skin" there have appeared photographs which I made years ago and which were labeled dermatitis seborrheica of the ears, scalp, and axillae. I did not accept some of those diagnoses then and I do not accept them now. Some of those cases were on an infectious basis due either to bacteria or to monilia. The scalp is susceptible to various infections such as impetigo and erysipelas due to streptococci, follicular lesions due to staphylococci, and also to the many fungi.

I wish to discuss now the etiology of dandruff. I have read all of the pros and cons and I do not ask you to accept my opinion on the subject. Dandruff is the disorder of the scalp most commonly seen in the dermatologist's office. Years ago in the horse and buggy days, an elderly physician, when asked about dandruff, snorted "Who ever saw a good horse that didn't have dandruff?" Those of you who remember my preceptor and associate will recall his thick, wavy, snow white hair, which he retained to the last, with no sign of alopecia. Some years after I left his office a patient came to me because of her dandruff. She stated that she had consulted my chief, but when she saw the dandruff on his blue coat collar she never returned. I told her that I had managed that very easily by always wearing a white coat in the office.

In the same display advertising quoted above appears this statement "Dandruff is always a sign of a diseased scalp whether other symptoms have appeared or not. Seborrheic eczema or dandruff is in my opinion a forerunner of most cases of senile baldness."

In all cases of scaling of the scalp I collect routinely the scales on a slide, press them carefully on to the glass with a knife blade, fix with heat, and stain with Loeffler methylene blue. In psoriasis or bacterial scaling the organisms of pityrosporum ovale will be absent or only an occasional organism will be seen, thereby making this technique an excellent aid in the differential diagnosis. It is constantly being said that pityrosporum can be demonstrated in the skin of most scalps. That statement is true. It also is true that staphylococci can be demonstrated in the follicles of all skins, hence the need for gloves in surgery. Streptococci are much less likely to be found on normal skin unless there is some focus of infection nearby, but may be found in the tonsils of patients with tonsillitis, and diphtheria and typhoid bacilli may be found in carriers. Pityrosporum ovale may be found in profusion in the scales of patches on the forehead, cheeks, and even on the chin in rare cases in scaly erythematous areas.

Is pityrosporum ovale a pathogen? We have heard much discussion in the past few years from the "Commies" and the "Fifth Amendment Amendmenters" on "guilt by association." If pityrosporum ovale is not a pathogen at least it can be convicted on guilt by association. It is a generally accepted fact that microsporon furfur is the pathogen involved in pityriasis versicolor and that microsporon minutissimum is the pathogen for erythrasma.

Conant[5] says "Microscopic examination of scales of erythrasma in 10 per cent potassium hydroxide in which the minute organisms may be seen definitely establishes the diagnosis." But he does not mention pityrosporum ovale in any capacity.

Lewis and Hopper[6], however, cite many references and state "There is still divided opinion among many investigators regarding the pathogenicity of pityrosporum ovale. Many feel that the work of Engman and his collaborators is decisive and that there is as much, if not more, proof of a casual relationship between pityrosporum ovale and dandruff a between microsporon furfur and tinea versicolor."

Quacks have been with us since the beginning of time and in all walks of life. The most harmless are the self-styled hair specialists. No harm is done by them because they keep hope springing eternal in the human breast. If the mother had taken her son to the "trichologist" in one of these quack places, instead of sending him to

me, he and she could have had their hopes all of those years, bolstered by the fact that they thought they were getting their money's worth.

I have noted that a well known band leader with a gorgeous growth of hair, for which no claim is made by the advertisers that it was grown by them, finds that the treatment given him is soothing and relaxing. I respectfully suggest that the quacks start working on an attempt to grow hair on the bald pate of a world famous conductor.

"Trichologists" are able to demonstrate that they have stopped the hair from falling but the weekly shampoos send all the loose hair down the drain and the client is unable to open his eyes or he will get an eyeful of detergent. Eventually, however, he may have his doubts but he also has his hopes, which sustain him for some time to come. Growing hair by the "trichologist," however, is not as easy to demonstrate except in alopecia areata, in cases of which, as said before, the hair may grow regardless of what is done or not done. The fad of brushing the hair with (one or two) a hundred strokes daily has always seemed to me to be a great waste of time and effort. After the hair has left the follicle it is on its own, much like the baby robin which has been pushed out of its nest by the mother. I was told, one time, by a septuagenarian woman that she gave her hair 200 strokes daily and a shampoo twice a year. I asked why the shampoo?

The best treatment I have yet found for pityrosporum ovale scaling (dandruff) in the scalp, is selenium sulfide (Selsun®). It is of no value in psoriatic scaling, of little value in so-called seborrheic dermatitis, and of no value in bacterial infections of the scalp. Therefore, it is of the utmost importance to determine the diagnosis by microscopic examination.

I've seen no case such as reported by Grover[7] describing the temporary loss of hair in females using Selsun. All of his six cases occurred in females, ranging in age from 18 to 56 years, and in all cases the falling was coincident with the use of Selsun and ceased with the cessation of its use. It is unfortunate that no further note is made of the scalp condition, other than that of "simple seborrheic dermatitis", whatever that is.

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CASE REPORTS

Accessory Thymus (Paratracheal) with Tracheal Obstruction

Irving Weissman, M.D., and W. C. Smith, M.D., Champaign

RESPIRATORY difficulty is not an uncommon problem in the newborn. Every radiologist has had occasion to examine chest roentgenograms of an infant with obstructive breathing referred by a clinician to determine the degree of thymic enlargement as a possible cause for the obstruction. It has always been our belief that enlargement of the thymus gland per se is rarely if ever a cause of tracheal compression or obstructive respiration.

Caffey[2] states: "There is no doubt that many large mediastinal shadows shrink after radiation treatment and do therefore represent large thymuses. But there is great doubt that such thymuses ever cause obstructive dyspnea or cyanosis. Careful studies of patients with obstructive symptoms usually demonstrate the real cause of the obstruction in such lesion as congenital obstructions in the respiratory or cardiovascular systems, cerebral disease, respiratory infections, or other disorders, many of which can be treated successfully. The roentgen diagnosis of enlargement of thymus gland, usually erroneous, tends to discourage investigations which are essential to accurate diagnosis and effective treatment."

Potter[6] in her book, "Pathology of Fetuses and Newborns" says: "Among the 8,000 autopsies on infants under 1 year of age that I have been fortunate enough to observe, the thymus has never shown any abnormality that might have led to death. It cannot be denied that infants occasionally die unexpectedly, but there is no evidence, unless an actual tumor is present, that the thymus is responsible or that X-ray treatment would have prevented death."

We are in accord with the opinions expressed by Caffey and Potter. The case reported here, however, is one in which we reported some enlargement of the thymus gland. But we could not blame it for the severe respiratory difficulty present in this infant, particularly since the tracheal shadow within the chest could be identified as air containing, both fluoroscopically and on film examination, without enroachment by the enlarged thymus. The infant was in poor condition with extreme dyspnea and died before further diagnostic procedures or definitive treatment could be instituted.

Postmortem findings of accessory thymus surrounding the trachea high in the neck and producing marked occlusion of it, (Figure 3) and —in the opinion of the pathologist as the prime cause of death—has given us much concern. Possibly a short course of radiation therapy directed to the neck would have reduced the size of the

From the Department of Radiology and Pediatrics, Christie Clinic, Champaign, Illinois

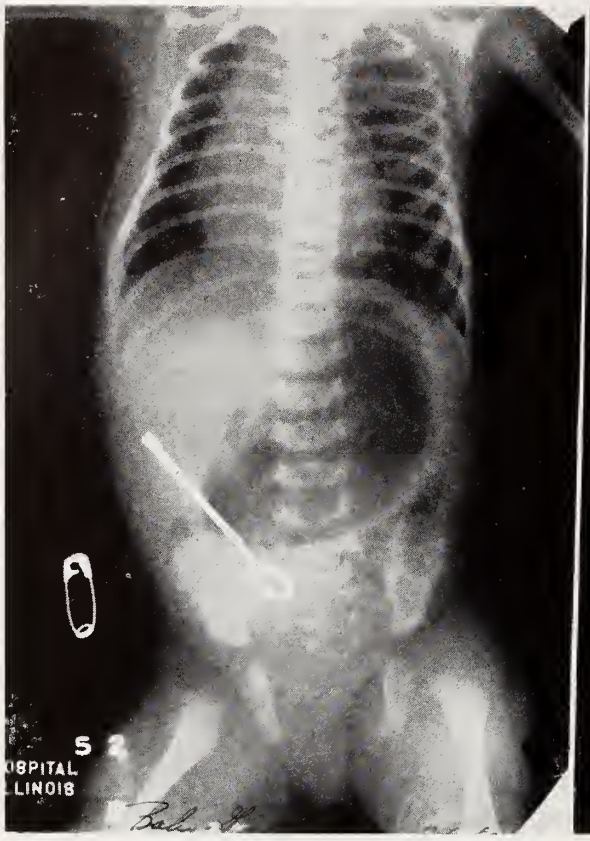


Figure 1. P.A. Preterminal chest film shows minimal enlargement of the thymus gland to the right. The film serves to show normally expanded lungs bilaterally with no evidence of congenital atelectasis.

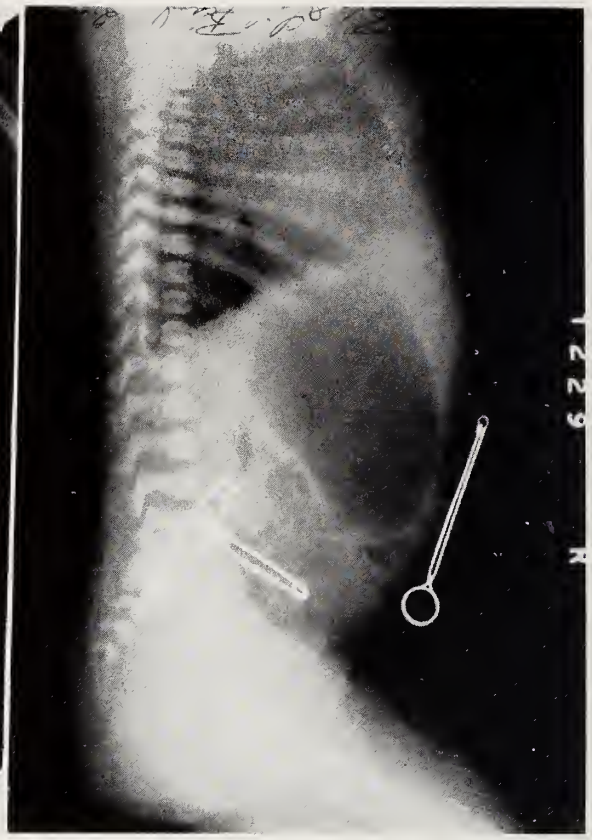


Figure 2. Lateral preterminal chest film shows air containing tracheal shadow, undoubtedly due to ball-valve block of the upper trachea.

aberrant gland and thus saved the life of this infant. We offer this case as one to be borne in mind when clinician and radiologist are searching for a possible cause of obstructive breathing in the newborn with or without evidence of thymic enlargement in the chest.

This infant was a full term, vertex spontaneous delivery. Pregnancy and delivery were uneventful. Respiratory distress was prominent from time of delivery. Respirations were labored and noisy and the infant was intensely cyanotic out of oxygen. The lung fields were full of crepitant rales. Clinical impression included: tracheal compression by congenital vascular ring, congenital atelectasis, cerebral disease, and encroachment on trachea by large thymus. Fluoroscopy of chest revealed symmetrical aeration of the lungs with some hyperaeration in the lung bases. There was no shift of heart or mediastinum. The diaphragm was depressed bilaterally with limited excursion on both sides suggestive of high tracheal obstruction. There was broadening of the supracardiac shadow believed to be due to enlargement of the thymus primarily to the right. The tracheal shadow in the chest was visualized and appeared normally air containing without encroachment or defect. The aorta appeared normal but barium swallow could not be given because of the poor condition of the patient (requiring continuous oxygen during the fluoroscopic procedure). The infant became markedly cyanotic and the examination was discontinued. These findings are confirmed by chest films (Figures 1 and 2).

Despite supportive treatment (continuous oxygen, respiratory and cardiac stimulants, and subcutaneous fluids) the infant's condition deteriorated steadily and she expired 24 hours postpartum.

Postmortem examination revealed the following salient findings: The thymus gland was enlarged, weighing 23 grams. It was soft in con-

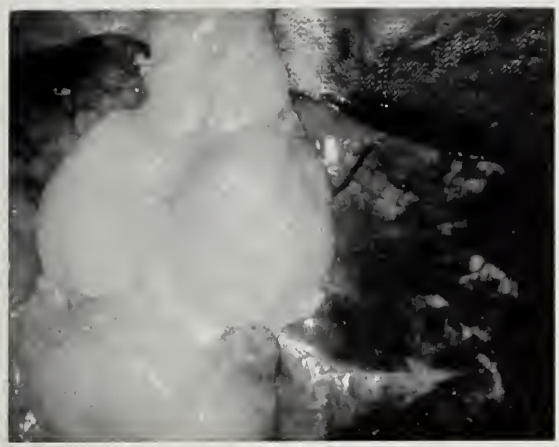


Figure 3. Postmortem specimen of trachea and mediastinum shows moderate, bilobar enlargement of the thymus gland with accessory paratracheal thymus producing marked constriction of the trachea, allowing only a fine probe through its lumen.

sistency and sectioned surfaces were pinkish-yellow and smooth. Extending from the superior pole of the thymus gland, two accessory lobes projected upward into the neck, extending as far as the lower border of the larynx, directly continuous with the main mass of thymus gland. The two lobes, joined in the midline, were symmetrical (Figure 3). Each lobe measured 3 cm. × 1.2 cm. in greatest dimensions. They almost completely encircled the trachea, producing marked narrowing of its lumen, barely permitting a probe to pass through it.

Microscopically, the ectopic tissue showed dense compact lymphoid tissue separated by vascularized connective tissue septa. The component cells had small dark round nuclei and scant cytoplasm. Distinct cortex and medulla were recognizable. In the medulla, the lymphocytes were few in number and were separated by reticulum cells. The medulla also contained numerous spherical or ovoid structures composed of concentrically arranged cells (Hassall's corpuscles). Diagnosis: Thymus gland.

Final pathological diagnosis included:

1. Accessory thymus gland in neck with marked constriction of trachea (Figure 3).
2. Enlargement of thymus gland.
3. Subpericardial and subpleural petachiae.
4. Acute tracheobronchitis.

DISCUSSION

The presence of a thymus gland in the neck can be logically explained embryologically. The thymus is an outgrowth of the third branchial pouch. According to Laage-Hellman, it developes also from the fourth branchial pouch. The parathyroids also develop from this site, the lower parathyroid coming from a thickening of the third branchial pouch and the upper parathyroids, from the fourth.

During fetal life the thymus reaches its final site in the anterior mediastinal cavity on the grounds of lengthening of the neck and some caudal movement. During this migration it passes the organs, developing from the fourth branchial pouch so that they finally lie cranially of the thymus. In addition to the upper parathyroid glands a thymus primordium — the so-called thymus IV — develops from the fourth branchial pouch. During fetal life, this thymus IV is situated, together with the parathyroids, beside the upper lobe of the thyroid gland, usually dorsally and medially of it. As a rule, however, the thymus IV disappears before the end of fetal life.

The occurrence of accessory thymus of the neck is not as a rule mentioned in textbooks of pathology and surgery. Gilmour[3] presents an interesting series of 13 cases of thymic tissue in unusual positions. In one there was bilateral and in another, unilateral hypoplasia of the thymus with complete absence of descent from its position in early embryonic life high in the neck. Four cases of left sided partial failure of descent of thymus III are recorded. In two the thoracic thymus extended high up into the neck; two had elongated accessory portions of thymus, the so-called thymus lobule III passing up into neck from a short distance above the upper pole of main thoracic thymus. Seven instances are described of inclusion of thymus IV within the thyroid.

Laage-Hellman[5] reports a case of accessory thymus tissue of the neck in an adult for which operation was performed. He further points out that aberrant or accessory glands should be counted among the potentially malignant tumors. Aberrant thyroid is stated to develop into cancer in 3 per cent of the cases (Lahey). Harmon[4] described a case in which thymus tissue was found in the lateral part of the neck, between the thyroid gland and hyoid bone. It was directly connected to the upper part of thymus. Bien[1] made the same observation in two newborn infants. In both, there was an attachment

to the normal thymus. In the latter case, two accessory thymus lobes were present in the neck. In none of the reported cases was death attributed to tracheal compression by accessory thymus but it would appear logical to assume that should such accessory thymic lobes become of the hyperplastic variety in the neck, tracheal compression and death would be inevitable. Such was the situation in the case reported here.

CONCLUSION

A case of accessory lobes of the thymus lying high in the neck, encircling and markedly compressing the trachea, is deschibed. The embryological explanation for the presence of thymus gland in the neck is discussed along with a short review of the literature.

It is our opinion that the radiologist should not assume a dogmatic attitude in opposition to obstructive dyspnea due to thymus gland in the newborn but should be mindful of anomalous accessory glands in the neck resulting in tracheal compression.

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Reciprocity with pride

The specialist, with his increased knowledge in one field, primarily a hospital and an office practice, the availability of a good laboratory and radiology department, should be respected for his contributions in detail and decision. To the general practitioner who is covering the waterfront, facing the day by day challenges of our vast American life, making innumerable decisions in the home, the office, and the hospital, guiding serious situations in the right paths for correction, and endeavoring to keep abreast of the new things in obstetrics as well as in internal medicine — to him must go his own dignity. There must not be created a sense of inferiority, a lowering of morale, a policy of looking down on a colleague, or a critical intolerant attitude. There are few specialists who — emotionally, physically, or intellectually — could stand in the shoes of many of our busy general practitioners today. Pride in our work is the greatest incentive to keep going in a difficult field. This must not be destroyed in either the general practitioner or the specialist. *A. D. Dennison, Jr., M.D. To Each His Own Dignity. J. Indiana M.A. March* 1957.

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Surgery for parkinsonism

There is a factual basis for judicious optimism regarding the future contribution of neurosurgical therapy to the welfare of patients with parkinsonism. In order for these potentialities to be realized, patients must be cautiously and judiciously selected as candidates for operation and operations of documented merit must be painstakingly performed. *Irving S. Cooper, M.D. Neurosurgical Alleviation of Parkinsonism. New York Acad. Med. Oct.* 1955.

EDITORIALS

Dr. Lester S. Reavley heads Illinois State Medical Society

A loss to education has turned out to be medical profession's gain.

In 1917, a grade school teacher in Riverton, Ill., decided after four years of teaching that he wanted to become a doctor. He entered Loyola University Medical School and in 1921 received his M.D. degree. On last May 23, that man was installed as President of the Illinois State Medical Society.

He is Dr. Lester S. Reavley of Sterling. The gavel was turned over to him by the retiring President, Dr. F. Lee Stone of Chicago, at the closing session of the House of Delegates 1957 annual meeting.

In the years intervening between the time Dr. Reavley started to practice in Sterling in 1922 until his elevation to his high office, he devoted a great deal of his time to the advancement of the profession in his county and state, and in the betterment of his community. Thus, it was a logical choice when he was selected to head his state Society, with a membership of more than 10,000 physicians.

Dr. Reavley was born in Springfield, Ill., June 17, 1894. His early education was received in the grade schools of Riverton and Springfield High School. He continued his studies at the Illinois State Normal University, Normal, and Valparaiso University, Valparaiso, Ind. After his graduation, he taught school for four years before taking up the study of medicine.

Dr. Reavley is a member of the Whiteside County Medical Society, Illinois State Medical Society, American Medical Association, American College of Surgeons and Industrial Medical Association. He has served his county society as president and was its secretary for 15 years. In the Illinois State Medical Society, he has served on numerous committees and was a member of the House of Delegates from 1925 until this year.

He also served as president of the staff and chief of surgery at the Community General Hospital, Sterling, for several years. He was a member of the Sterling school board for more than 15 years and president of the board for eight years. When the National Bank of Sterling was organized in 1934, he became director, later served as president and now is chairman of the board of directors.

Dr. Reavley is married and has a daughter, Mrs. William H. Dahlke of Minneapolis, and a son, David, 22. He is a member of the Riverton (Ill.) Masonic Lodge; Sterling Elks Lodge; Gyro Club, which is interested in physically handicapped children, and the American Legion.

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Dr. Raleigh C. Oldfield is chosen president-elect

Dr. Raleigh Charles Oldfield, who has practiced in Oak Park for 41 years, was chosen pres-

ident-elect of the Illinois State Medieal Soeiety at the last annual meeting. Dr. Oldfield has been active in the affairs of the Soeiety, being a member of the Council at the time of his election to his present post.

He was born in Chicago, December 9, 1892, and obtained his M.D. degree from Loyola University in 1915. After interning in the West Suburban Hospital, Oak Park, he joined the staff and has been associated with the hospital ever sinee. He taught nurses there for 15 years and presently is a member of the executive surgieal staff, seeretary of the board of trustees and committee on nursing education and member of numerous committees.

After his internship he joined the Aux Plaines Branch of the Chicago Medical Society and began an active career in medieal society services which will carry him to the leadership of his state Society in May 1958.

Dr. Oldfield is an organizer. He called the first meeting and organized the Past Presidents Club of the Aux Plaines Branch; is a charter member and president of the Aux Plaines Welfare Club, whieh gives widows of members $200 within 24 hours after the death of a member, and a charter member and first president of the Intern-Resident Alumni Association of West Suburban Hospital.

After serving as president of the Aux Plaines Branch in 1930 he was sent to the Chicago Medieal Society as a councilor, a position which he still holds. He has served on numerous committees of the C.M.S., and for many years was ehairman of the Committee to Investigate and Consider Informal Charges of Unethical Conduct.

He became a Councilor of the Illinois State Medical Society in 1951 and served as first vice-president in 1948. He is or has been a member of numerous committees, including Executive, Postgraduate Educational, Ethical Relations and Journal. He has represented the Society on the Department of Nurses Education and Registration for Illinois.

He was taught surgery at Loyola Universtiy Stritch Sehool of Medicine. He is on the consulting staff of the Westlake Hospital, a fellow of the American College of Surgeons and International College of Surgeons, a member of the Oak Park Club and Oak Park-River Forest Physieians Club, and Mason and Shriner.

Dr. Oldfield married Miss Margaret Evans in 1919. They live at 539 Jackson Avenue, River Forest. They have one son, Dr. R. Charles Oldfield, Jr., a thoracic and cardiovascular surgeon; two daughters, Mrs. Elizabeth O. Spaulding and Mrs. Margaret P. Maloney, and five grandchildren.

His office is at 715 Lake Street, Oak Park.

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Illinois State Medical Society honors Mrs. Beatrice Gilmore

The Illinois State Medical Society at its annual banquet, May 22, paid tribute to a grand lady who while her husband was in service abroad in World War I carried on the duties of Secretary of the Society.

Dr. F. Lee Stone, President, presented to Mrs. Beatriee Gilmore, a bouquet of American Beauty roses. Earlier in the day, Mrs. Gilmore had been inducted into the 50 Year Club of the Illinois State Medical Society by Dr. Andy Hall of Mount Vernon, who at 93 is still an active general practitioner.

Mrs. Gilmore received her M.D. degree from the Woman's College of Philadelphia in 1905, shortly after her marriage to Dr. Wilbur H. Gilmore. She had high ambitions as a newly made physician.

Her husband had different ideas. He did not believe in "hen medics," as he called those of the opposite sex who dared to enter the medieal profession. He also felt that the way to get rid of them was to marry them. His will prevailed after her graduation, and she did not enter praetice.

However, when Dr. Gilmore was eleeted Secretary of the Illinois State Medical Society in 1913, his wife helped him in his duties. So, it came to pass that when he went overseas, she was named assistant secretary and authorized to carry on the work of her husband. Dr. C. W. Lillie of East St. Louis was named second assistant secretary and functioned at Council meetings at which she could not be present. She held the position until the return of her husband in 1918.

Although Mrs. Gilmore has never practiced medicine, she has always worked in behalf of



Lester S. Reavley, M.D.
President, Illinois State Medical Society
1957-1958

the profession. A son, Dr. John H. Gilmore, is a radiologist at the Illinois Masonic Hospital, Chicago, following the specialty of his father, who died in 1935.

"It is appropriate that Illinois medicine should pay honor to this gallant lady," Dr. Stone said.

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Illinois State Medical Society presents awards to laymen

The annual awards of the Illinois State Medical Society to a layman and a lay group for meritorious service to the medical profession this year went to a state public health official and to four science writers. Presentation of the certificates was made by Dr. F. Lee Stone, President of the Society, at the annual banquet on May 22.



Mr. B. K. Richardson

The individual award went to Baxter K. Richardson, deputy director of the Illinois Department of Public Health for the last 16 years. Group recognition was given to the science writers, Mrs. Effie Alley of the Chicago American; Roy J. Gibbons of the Chicago Tribune, Robert Kleckner of the Chicago Sun-Times and Arthur J. Snider of the Chicago Daily News.

Dr. Stone pointed out that Mr. Richardson in 38 years of service in the Illinois Department of Public Health "developed modern concepts of public health education in this state;" has had much to do with the training and establishment of health educators as a professional specialty in the state, and has been instrumental in the organization of full-time local health departments in 27 counties. In this work, he earned the esteem of the medical profession.

In presenting the group award, Dr. Stone said the science writers have been keeping the public informed as to "what the profession has done and is doing in minimizing pain, conquering disease and prolonging life." An informed public, he said, is "our greatest weapon against socialized medicine in this country."

Mrs. Alley received her B.A. degree from the University of Arkansas. She worked on newspapers in Little Rock and Sioux City before joining the Chicago American in 1938. She began her science writing in 1940 with a series called "Night Nurse," relating activities at Cook County Hospital.

Mr. Gibbons was educated in St. Ignatius College, Cleveland. He entered newspaper work in 1917 and 16 years ago joined the Chicago Tribune as a correspondent in New York. He took up science writing and in 1946-1947 was a member of the Admiral Byrd expedition to the Antarctica.

Mr. Kleckner is a graduate of the University of Missouri, where he took a pre-medical course. He worked on several newspapers and for the Associated Press before becoming assistant city editor for the Chicago Times (now Sun-Times) in 1941. For the last 10 years he also has served as science writer.

Mr. Snider received his B.A. degree from the University of Iowa and M.S. from Northwestern University, where he studied specifically for science writing. He became science editor of the Chicago Daily News in 1946 and in 1948 won the Headliners Club award for science writing. He is past president of the National Association of Science Writers.

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1957 annual meeting highlights

On Thursday evening, May 23, the official gavel of the Illinois State Medical Society was presented to Dr. Lester S. Reavley of Sterling by the retiring president, Dr. F. Lee Stone of Chicago.

The election, held earlier that evening resulted in the following assuming office for the 1957-1958 fiscal year:

OFFICERS:

President: Lester S. Reavley, Sterling
President Elect: Raleigh C. Oldfield, Oak Park
1st Vice-President: Paul A. Dailey, Carrollton
2nd Vice-President: Patrick H. McNulty, Chicago
Secretary-Treasurer: Harold M. Camp, Monmouth

COUNCILORS

1st District: Carl E. Clark, Sycamore
2nd District: Joseph T. O'Neill, Ottawa
3rd District: Earl H. Blair, Chicago

E. A. Piszczek, Chicago
H. Close Hesseltine, Chicago
Caesar Portes, Chicago
Harry J. Dooley, Oak Park
4th District: Charles P. Blair, Monmouth
5th District: Jacob E. Reisch, Springfield
6th District: Newton DuPuy, Quincy
7th District: Arthur F. Goodyear, Decatur
8th District: Harlin English, Danville
9th District: Burtis E. Montgomery, Harrisburg
10th District: Willard W. Fullerton, Sparta
11th District: Edwin S. Hamilton, Kankakee
Councilor at large: F. Lee Stone, Chicago

At a meeting of the Council held Friday morning, May 24, Dr. H. Close Hesseltine of Chicago was elected to serve a second year as Chairman of the Council.

A.M.A. Delegates

Illinois will be represented in the A.M.A. House during the next year by the following delegates and alternate delegates:

Delegates

Percy E. Hopkins, Chicago
Warren W. Furey, Chicago
Carl F. Steinhoff, Chicago
H. Kenneth Scatliff, Chicago
Walter C. Bornemeier, Chicago
C. Paul White, Kewanee
Burtis E. Montgomery, Harrisburg
J. M. Pfeiffenberger, Alton
Harlan English, Danville
Everett P. Coleman, Canton

Alternates

Maurice M. Hoeltgen, Chicago
Leo P. A. Sweeney, Chicago
Norris J. Heckel, Chicago
Eugene T. McEnery, Chicago
Frank H. Fowler, Chicago
Harry Mantz, Alton
Joseph T. O'Neill, Ottawa
Arthur F. Goodyear, Decatur
George Kirby, Spring Valley
Robert Heerens, Rockford

State Society Dues for 1958

By official action on the part of the House of Delegates of the Illinois State Medical Society, the 1958 annual dues will remain the same. The per capita assessment is $40.00. Of this amount, $20.00 is allocated to the American Medical Education Foundation; $2.00 goes into the Benevolence Fund, and the remaining $18.00 is deposited to the general funds of the State Society.

Therefore the county medical society secretary will send to the Monmouth office of the Secretary - Treasurer:

State Medical Society dues of $40.00
American Medical Association dues of 25.00
$65.00 per member

CONSTITUTION AND BY LAWS AMENDED

Article IV, Section 3, EMERITUS MEMBERS of the Constitution was changed by proper action of the House of Delegates to read as follows:

"*A member who has been in good standing continuously for thirty-five years and who has reached the age of seventy,* may upon application to and upon recommendation of his component society, be made an Emeritus Member and have all the rights and privileges of membership without the payment of dues to the component or state society."

The House of Delegates and the Council stressed the fact that Emeritus Membership was an honor to which a man was elected by his county and state societies, and not an automatic action taken in every case.

Attendance at the meeting

Physicians	2,034
Woman's Auxilary	323
Technical Exhibitors	271
Guests (interns, students, nurses, etc.)	678
	3,306

AWARDS FOR SCIENTIFIC EXHIBITS

For Educational Value:

Gold Medal: Title: "Benign Diseases of the Pancreas." Exhibitor: Charles B. Puestow and W. J. Gillesby. Institution: Veterans Administration Hospital, Hines.

Silver Medal: Title: "Alopecia Capitis General Etiologic Survey: (A Practical Teaching Classification)." Exhibitor: Julius E. Ginsberg and Bruce Bairstowe. Institution: Northwestern University Medical School.

Bronze Medals: Title: "Gynecologic Surgery-Illustrations, Discussions of Technique, Pitfalls and Complications." Exhibitor: Walter J. Reich

and Mitchell J. Nechtow. Institution: Cook County Hospital, Cook County Post-Graduate School and Chicago Medical School. Title: "The Undescended Testes Problem." Exhibitor: Norris J. Heckel, James H. McDonald and James A. Calams. Institution: University of Illinois College of Medicine, Presbyterian Hospital and Ravenswood Hospital. Title: "Maxillo-Facial Injuries." Exhibitor: Robert M. Booth.

Original Work:

Gold Medal: Title: "The Viral Etiology of Leukemia." Exhibitor: Steven O. Schwartz, H. M. Schoolman, P.B. Szanto, Wilma Spurrier, and LeRoy Yates. Institution: The Hektoen Institute for Medical Research of the Cook County Hospital, Chicago.

Silver Medal: Title: "Dermal and Epidermal Melanocytes." Exhibitor: Arnold A. Zimmerman and Samuel W. Becker, Jr. Institution: Departments of Anatomy and Dermatology University of Illinois College of Medicine.

Bronze Medals: Title: "Regulation of Physical Activity in Management of Chronic Disease." Exhibitor: Edward E. Gordon. Institution: Michael Reese Hospital, Chicago. Title: "EEG Studies and the Use of Tranquillizer Drugs in the Care of Children with Reading, Speech, and Adjustment Problems in School." Exhibitor: Homer F. Weir and Robert L. Anderson. Institution: Rockford Memorial Hospital, Rockford. Title: "Sex Chromatin in Sexual Anomalies." Exhibitor: Joseph H. Kiefer, Ira Rosenthal, Elizabeth McGrew, and I. Pat Bronstein. Institution: University of Illinois College of Medicine.

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State society makes record gift to medical education

Dr. Lester S. Reavley of Sterling, President of the Illinois State Medical Society, and Dr. Harold M. Camp of Monmouth, Secretary-Treasurer, presented $170,450 to the American Medical Education Foundation at a meeting of the A.M.A. House of Delegates in New York, June 5, setting a new record.

In making the presentation to Dr. Louis H. Bauer, President of the Foundation, Dr. Reavley said the contribution represented gifts from every member of the Society. Other contributions by Illinois doctors will bring this year's total to more than $200,000. Last year, a then record check of $164,914 was presented by Illinois.



Money Talks, Illinois doctors say, as Dr. Harold M. Camp, Secretary-Treasurer of the Illinois State Medical Society (kneeling left), and Dr. Lester S. Reavley, President of the State Society (extreme right), turn $170,450 over to Dr. Louis H. Bauer, President of the American Medical Education Foundation, for medical education. The gift from Illinois doctors set a new high mark.

"Our doctors in Illinois believe that if medical education in this country is to be kept free of government control, financial support must come from the profession, industry and the public," Dr. Reavley said.

"We backed up this opinion at our annual meeting by again allocating $20 per member to the American Medical Education Foundation."

Dr. Bauer, in turn, complimented the Illinois State Medical Society for setting the pace in support of medical education and presented Dr. Reavley for the State Society with the A.M.A. Award of Merit for "contribution to the preservation and continuance of the high standards of medical education in the United States."

The American Medical Education Foundation was organized in 1951. Since then, Illinois physicians have contributed about $1,000,000, or far in access of the amount received from any other state.

Dr. E. S. Hamilton named chairman of A.M.A. Board of Trustees

Signal honor and recognition for an Illinois physician came out of the American Medical Association's recent annual meeting in New York when Dr. Edwin S. Hamilton of Kankakee was elected to the important post of chairman of the A.M.A. Board of Trustees.



Edwin S. Hamilton

Dr. Hamilton, whose family has been associated with the medical profession in Kankakee for more than three quarters of a century, has been active in the affairs of the A.M.A. for nearly 20 years. He took over the chairmanship from Dr. Gunnar Gundersen of LaCrosse, Wis., the new President-elect.

Dr. Hamilton has served several times as secretary of his Kankakee County Medical Society and as its vice-president, and has always been one of its active members.

At the state level, he has represented his district in the Council of the Illinois State Medical Society since 1932, serving through much of that time on its key committees. And he has served since its inception on the joint committee by which the Society and the Illinois Agricultural Association have financed the education of some eighty-three students for rural practice. He was one of our delegates to the American Medical Association from 1936 to 1948.

At the national level, Dr. Hamilton has served as secretary of the Board of Trustees of the American Medical Association, having been elected in 1948 and re-elected in 1953. His terms have covered the most trying period in the history of American medicine. Perhaps his major service as a trustee was as a member of the coordinating committee which supervised the fight against the Wagner-Murray-Dingell bills. In addition, he has served as chairman of the Task Force appointed by the Board of Trustees to confer with the Department of Defense in the development of the Medicare program.

Dr. Hamilton was a founder and is still delegate of the World Medical Association, past president of the New York Central Railroad Surgeons' Association, trustee of the International Postgraduate Medical Assembly, and vice-chairman of the National Conference on Care of the Long-term Patient. He has served for years on the Medical Examining Committee of the Department of Registration and Education of Illinois.

In his community services—American Legion, Chamber of Commerce, Kiwanis, Elks, the Shrine, as a trustee of the Methodist Church, as a bank president—he has stood before the public as a symbol of all that is best in the medical profession.

Dr. Hamilton speaks well and has a broad intelligent grasp of medical affairs at all levels. He is able and willing to give the time to the office which it requires today.

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Wisconsin surgeon chosen A.M.A. President-elect

A 60-year-old surgeon from a neighboring state was chosen President-elect of the American Medical Association at the annual meeting in New York. He is Dr. Gunnar Gundersen of LaCrosse, Wis. Dr. Gundersen, who was elected unanimously, will take over the Presidency at the 1958 annual meeting in San Francisco.



Gunnar Gundersen

Born in LaCrosse in 1897, he began the private practice of medicine in 1922 as an associate of his father. He now operates the Gundersen Clinic in LaCrosse, along with three of his physician brothers. Two other brothers practice medicine in the New England area.

Dr. Gundersen, who is well known to Illinois medicine, was President of the State Medical Society of Wisconsin for 1941-42, and has been a member of the A.M.A. Board of Trustees since 1948, becoming chairman of the board in June 1955.

He is a diplomate of the American Board of Surgery, a fellow of the American College of

Surgeons and International College of Surgeons, a member of the Council of the World Medical Association, and a member of the American Public Health Association.

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A.M.A. Distinguished Service Award

The A.M.A. Distinguished Service Award for 1957 was presented to Dr. Tom Douglas Spies, head of the department of nutrition and metabolism at Northwestern University Medical School, Chicago, and director of the nutrition clinic at Hillman Hospital, Birmingham.



Tom D. Spies

The presentation, made at the A.M.A. annual meeting in New York, was for Dr. Spies' outstanding contribution to the science of human nutrition. He is the 20th physician to receive the annual award. His work in the field of nutrition has brought him international recognition.

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New principles of medical ethics

For the past two or three years, the A.M.A. House of Delegates has been working on a revision of the old Principles of Medical Ethics. At the 1956 annual meeting, eight of the ten short principles were approved, and the Committee on Constitution and By-laws of the A.M.A. was directed to rewrite sections 6 and 7.

This was done and the newly revised principles were presented at the annual meeting held recently at New York. The long discussed revision as revised by the committee was approved at the final session of the House on June 6.

The new, recently approved version now reads as follows:

"PREAMBLE

"These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

"*Section 1.*—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

"*Section 2.*—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

"*Section 3.*—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

"*Section 4.*—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

"*Section 5.*—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

"*Section 6.*—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

"*Section 7.*—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be disposed or supplied by the physician provided it is in the best interests of the patient.

"*Section 8.*—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

"*Section 9.*—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

"*Section 10.*—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community."

In approving the new Principles of Medical

Ethics, the House of Delegates also reaffirmed the "Guides for Conduct for Physicians in Relationships with Institutions," adopted in 1951, and requested the Board of Trustees to devise and initiate a campaign to educate both physicians and the general public to the dangers inherent in the illegal corporate practice of medicine in its various forms.

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Dr. John L. Reichert named to Chicago school board

Dr. John Lester Reichert of Chicago, a Councilor of the Illinois State Medical Society for the Third District, was named by Mayor Daley to fill a vacancy on the Chicago Board of Education. The term is for five years.



John L. Reichert

An assistant professor of pediatrics at the Northwestern University Medical School, Dr. Reichert succeeds Dr. Robert S. Berghoff who served two five-year terms with distinction.

Dr. Reichert is active in the affairs of the Illinois State Medical Society. He is a co-chairman of the Sub-Committee on School Health, and a member of the Journal, Mental Health, Nursing and Postgraduate Education and Scientific Service Committees. He also is chairman of the Health Committees of the Chicago Medical Society and Chicago Pediatrics Society, and vice chairman of the Illinois Joint Committee on School Health.

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Poliomyelitis vaccination as a year-round procedure

In January of this year the American Medical Association and other medical groups instituted a campaign urging the public to get vaccinated against polio. The unexpectedly large response to this advice was the main factor in the depletion of supplies of vaccine, and for the present shortage. The supply of vaccine is now gradually increasing. Another pertinent fact in the present situation is the opinion of practically all authorities that giving polio vaccine through the season of polio is a safe and proper procedure.

In view of these facts, and in order to minimize peak loads with a probable repetition of the present shortage, the Committee on Poliomyelitis Vaccine Control of the Illinois State Medical Society recommends and urges that physicians continue to vaccinate their patients against polio throughout the year.

The recommended dosage schedule is to give 1cc. of vaccine to be followed in two weeks or longer by a second dose of 1 cc., in turn to be followed in seven months, or longer, by a third dose of 1 cc. There is no indication at the present time for the need of a fourth dose.

COMMITTEE ON POLIOMYELITIS VACCINE CONTROL

John Lester Reichert, M.D., Chairman
T. R. Van Dellen, M.D.
J. C. Redington, M.D.
Joseph T. O'Neill, M.D.
James A. Conner, M.D.

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Colleagues and community pay honor to Dr. Reavley

Dr. Lester S. Reavley of Sterling, the newly installed President of the Illinois State Medical Society, was honored by his colleagues and his neighbors at a testimonial dinner in Gordon's Restaurant, Sterling, May 27.

Mayor Floyd B. Higby, Sr., state and county medical society officials and others paid tribute to Dr. Reavley's services. About 175 attended the dinner, which was sponsored by the Whiteside County Medical Society and Lee County Medical Society. Mrs. Reavley also was praised for her understanding of what a conscientious doctor's work entails, and for her support of his activities.

Dr. Reavley, in his response laid down a few rules for an ideal physician, which he admitted could not be followed in entirety. He said:

"The ideal physician must be of a fine and scholarly appearance and of great intellectual capacity; of faultless personal habits and inspire the confidence of his patients, and the respect of all others. He must be active in community affairs, taking his full part in Chamber of Commerce and service club functions; serve

on and advise municipal and other governmental bodies when called upon; be active in local and state political affairs; be a good church worker and attend church regularly.

"He must be available on short notice for papers to local PTA, and church groups, service and business girl clubs, and all other groups and organizations interested in obtaining reliable information on medical subjects. He must take an active part in various programs of the community.

"He must be active in his local and state medical societies, attend meetings regularly, and accept office and committee assignments eagerly and perform his duties quickly and with great tact and diplomacy. He must be faithful in attending hospital staff meetings; be ready to give prepared scientific papers; serve on hospital committees cheerfully; and efficiently keep his hospital records complete in all details; be prompt with carefully prepared lectures to student nurses.

"He must be a good family man, with a gracious and tactful wife; he must spend lots of time at home with his children. Above all this, he must never fail to give his patients the finest possible medical service, keeping abreast of medical progress by reading, attending medical meetings and taking frequent post-graduate courses. He must be a tireless worker, and improve his public relations by spending adequate time with his patients, answering urgent calls promptly, day or night, and by not keeping his patients waiting. This must of all certainty be done for what has been vaguely defined as a reasonable fee."

Dr. Leroy Danreiter, President of the Whiteside County Medical Society, called the selection of Dr. Reavley to head the physicians of Illinois as a "well deserved honor." Dr. John McDonnell, who served as toastmaster, said the honored guest served his profession well and has given "unselfish service to his community in educational, civic and industrial affairs."

Mayor Higby paid tribute to Dr. Reavley as his family doctor of 33 years standing and congratulated him for "coming up the hard way," from a lad of poor parents in a coal mining town to the head of an organization of more than 10,000 doctors.

Dr. Harold M. Camp, Secretary-Treasurer of the Illinois State Medical Society, said the Society will be well conducted under the new President but warned his neighbors to be prepared to miss him a lot because the duties involve a great deal of travel.

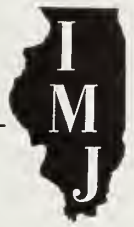
Dr. Camp displayed a check for $170,450 and announced that this was being turned over to the American Medical Education Foundation as a contribution of Illinois doctors toward medical education. With other contributions, this year's total will surpass $200,000 and bring the overall total to more than $1,000,000, placing Illinois far ahead of all other states in gifts of doctors to medical education.

Dr. Murray E. Rolens of Springfield, college roommate of Dr. Reavley, and Paul Phillips, Secretary of the Sterling-Rock Falls Chamber of Commerce, also paid tribute to the guest of honor.

Among others present were Dr. C. Paul White of Kewanee, Past President; Dr. Carl E. Clark of Sycamore and Dr. Joseph T. O'Neill of Ottawa, Councilors, and Dr. George E. Kirby, Co-Chairman of the Postgraduate Medical Education and Scientific Service Committee.

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MEDICAL ECONOMICS



Crossroads

WILLARD W. FULLERTON, M.D., SPARTA

The misunderstandings between the Illinois State Medieal Society and the officials of the United Mine Workers Welfare and Retirement Fund have brought to attention some of the economic phases of future medicine in the relation with third parties and the future considerations of what shall constitute the rights of the physician, the rights of the patient and the rights of third parties.

The concept of American medicine mentions that the patient should have the right to choose his physician; and, ? that physicians should be paid on a fee basis.

The United Mine Workers Welfare and Retirement Fund started operating some seven or eight years ago and in the first attempt to provide medical care for the members and their dependents endeavored to pay all medical services including home visits, office visits, hospital, obstetrical and surgical benefits. This was a grand gesture from a paternalistic point of view, but not sound actuarially. The paternalistic directors of the Fund realized after a few months that such a program could not be handled with their resources. The program was then stopped for a time and when it was resumed they offered medical, surgical and obstetrical care only to hospital-confined patients and sometimes on emergencies in the office of physicians.

While doing all of this, the directors developed a list of cooperating physicians which, technically, was not a proper term as most physieians are willing to cooperate, at least to some extent. As always there are a few physicians who need some disciplinary action or at least control in what they do. The Fund officials have always used some excuse for any change in their policies and never allowed the medical profession to correct defects or to discipline members.

The directors issued instructions under the date of November 1, 1955 in which they expected only board surgeons or board eligible surgeons to do the major surgery. It was not stated on what date it would actually become effective, but in dealing with various doctors who continued to do surgery for them the doctors were strongly reminded of the direetive of November 1, 1955. In other words, they used the directive as a policy while not admitting to the Advisory Committee of the Illinois State Medical Society that it had actually been given an authoritative date.

Then an attempt was made to make some kind of an agreement with the United Mine Workers for the physicians of Illinois. Practically all members of the Committee assembled on December 13, 1956 to meet with the District Director. Some of these members had traveled over 300 miles only to have the Director state that he was not signing any contract in view of the fact that the contract basis had fallen down in Pennsylvania. It is probably not a province of the Illinois State Medical Society to answer for the difficulties arising in the State of Pennsylvania. However, the American Medical Association, which apparently was expected to act as a bargaining agent for the physicians in this country, as far as the United Mine Workers are coneerned, more or

less had to take into consideration the problems as presented all over the country. Thus, we are dealing on one hand with a democratic organization attempting to work out an agreement with another organization which directs its policies from above—downward. This policy most union local secretaries will vouch for. There was a resolution by the Advisory Committee of the Illinois State Medical Society to the United Mine Workers Welfare and Retirement Fund presented to the Council of the State Medical Society on its December 14, 1956 meeting which essentially was this: The doctors would not deal with the Fund but would deal directly with the coal miner himself and would bill the coal miner for his medical, surgical and obstetrical services. Second, it was generally to be construed that doctors who did not conform to this recommendation could possibly be subjected to disciplinary action of his county medical society. This was the recommendation of the Advisory Committee and of the Council. However, for this to be effective it would have to be adopted by the various county medical societies as their own policy or it would have to be confirmed by the House of Delegates of the Illinois State Medical Society.

It is, probably, pertinent at this time to review the past and the probable thinking of the directors of this particular Fund. As it has been related, they used all physicians to begin with; then they developed a list of cooperating physicians and the methods by which some doctors were accepted on the list of cooperating physicians and the others were left off were various. Some men were dropped because they had very few cases for them. Some men were dropped because they were accused of charging excessive fees. Some were dropped because of what they considered inadequate service. All of this was done entirely by their own decision and their complaints against physicians was not a result of any disciplinary committee of his respective county medical society or his hospital board. That was the first line of division in the process of dividing and conquering. It is quite obvious that they wish to direct not only the physicians who do their work but direct the choice of physicians for the recipients of their program.

The present process is to divide the general practitioner from the specialist with specialist being the man to receive all the favors from the patient load and consequently the financial return from work done. The general practitioners are being gradually eliminated from the program entirely. It is not an unfathomable deduction that the next process would be that they hire their own board specialists on a salary or retainer basis which they undoubtedly could do at a much lower cost than the fee basis specialist; therefore, eliminating the specialists of the fee basis classification and using their own hired salaried men. By this time they could expect a very futile cry from the fee basis specialist because the medical profession and the general practitioners would no longer be interested in the worries of the specialist since the specialists had taken over the present problem.

Therefore, if we are to remain in command of our own business, in command of the care of our patients, to get paid in accordance to the work we do and to keep the free choice of physicians as a right of the patient, it is time now for the general practitioner and the specialist to foresee the inevitable pitfalls that can come as a result of looking at the practice of medicine from a purely economical and selfish return to the individual doctor: The process of directing patients for their medical, surgical and obstetrical care to specialists only is depriving many very capable general practitioners of a sizeable amount of their income in some instances and putting him in an embarrassing situation when he has to explain why he cannot do work for coal miners that he has been doing for years and work that he is continuing to do for other people. Now is the time for unity of the medical profession in all its branches and divisions regardless of our certifications. If the general practitioner is to retain any prestige, as a Doctor of Medicine, the specialists must help to preserve part of his dignity. Otherwise, the general practitioner will only be an M.D. who in the eyes of the public and the eyes of his patient is very little better than a doctor of osteopathy.

"A house divided against itself will not stand," as quoted from Abraham Lincoln.

THE P. R. PAGE

Edward A. Uzemack, Director of Public Relations

"No physician, in so far as he is a physician, considers his own good in what he prescribes, but the good of his patient; for the true physician is also a ruler having the human body as a subject, and is not a mere money-maker."—Plato

Good public relations does not have to cost a cent, Paul Jones, director of public information for the National Safety Council, told 226 doctors and their wives at the annual Public Relations Dinner of the Illinois State Medical Society.

Sponsored by the Committee on Medical Service and Public Relations, the dinner was held in conjunction with the 117th annual meeting of the Society in Chicago's Hotel Sherman. Mr. Jones' address was regarded by many as a highlight of the four-day session.

"There is no mystery about public relations," he said, "despite the elegance and expense with which it is sometimes cloaked. It is simply the Golden Rule applied to modern living. It is merely being fair and thoughtful and courteous and friendly to the people with whom you deal.

"Public relations is just that simple. And yet for the lack of it many a worthy cause has failed to get the support it deserves, and many a business has gone to the wall.

"Failure to treat other people courteously and the absence of a desire to give real service are costing this country many millions of dollars a month. Ironically, good public relations doesn't have to cost a cent. Anyone can practice it who really wants to."

In the field of public service, Jones said the success of efforts to sell a cause to the public depends largely on three things.

"First," he said, "the cause must be worthy. Second, the people behind it must be sincere. Third, the public must be fully and intelligently and honestly informed on what the cause is trying to achieve, and the need for it."

In fulfilling his assignment to bring physicians some views on how PR techniques of other fields can be applied to the medical profession, Jones also proved himself a raconteur of extraordinary ability. A PR expert of national renown, he gave his audience a pleasant blend of wisdom and humor.

Jones said that everyone is a salesman, whether he knows it or not. He advised that no matter what a person is selling, he should be explicit, fair and friendly.

"Nowhere is the need for salesmanship—and by that I mean warm, human and sympathetic treatment of the customer—more urgent than in anything relating to illness," he declared.

"Patients are sick and very often frightened

people. If anyone ever needed and deserved friendly kindness and special treatment, it is a patient—especially when he's in a hospital."

Jones praised the Illinois State Medical Society and the medical profession in general for the leadership they are giving in accident prevention. "It is a natural alliance," he said, "and is a tremendous boon to safety."

He explained that rudeness and discourtesy towards others—a "me first" attitude—causes most traffic accidents, and "messes up things in general." As an antidote, he suggested greater effort to bring about a more general understanding of fundamental public relations on the part of the average person.

Dr. Percy E. Hopkins, chairman of the Committee on Medical Service and Public Relations, served as toastmaster at the dinner, which preceded the Beau Belle Ball arranged by the Woman's Auxiliary to the Illinois State Medical Society. He attributed the excellent attendance at the PR Dinner to the "untiring efforts of the Auxiliary in publicizing the event and promoting the sale of tickets."

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AMA's 1957 PR Institute

The American Medical Association's new film for the public—"Whitehall 4-1500"—will be premiered at the annual Public Relations Institute in Chicago's Drake Hotel on August 28.

News Commentator John Cameron Swayze serves as narrator for the 30-minute color film, slated for release to medical societies on September 1. The movie tells the story behind the phone number which is so well known to physicians all over the country.

Dramatic, short sequences show how AMA in action helps save youngsters' lives through poison control activities, reduces highway deaths, places physicians in isolated areas, and makes jobs safer for industrial workers and life better for everyone.

This year's Institute will be concerned with problems of science writers in developing stories of national significance, problems of the working press in covering local medical news, ethical considerations of distinguishing between advertising and legitimate medical news, the status of grievance committees and how they can work more efficiently.

County medical society executives and public relations committee chairmen are especially urged to attend this conference.

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Open letter to Auxiliary presidents

The following is an open letter addressed to the presidents of the Woman's Auxiliary to the Illinois State Medical Society:

"Dear Madam President:

"On behalf of the Committee on Medical Service and Public Relations, I wish to thank you and your members for your cooperation in promoting ticket sales and publicizing the annual Public Relations Dinner at the Hotel Sherman, Chicago, during the 1957 meeting of the Illinois State Medical Society.

"We had an attendance of 226 persons, all of whom appeared to be delighted with the evening's program, so ably highlighted by the address of Mr. Paul Jones, public relations director of the National Safety Council. Without your assistance we would have had difficulty in getting such a splendid turnout.

"Once again the Woman's Auxiliary has demonstrated its sincere desire to spur the public relations programs of the State Medical Society.

Sincerely,

Percy E. Hopkins,
Chairman Committee on
Medical Service and
Public Relations

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CORRESPONDENCE



Clinics for crippled children listed for August

Twenty one clinics for Illinois' physically handicapped children have been scheduled for August by the University of Illinois, Division of Services for Crippled Children. The Division will count 15 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing service. There will be 3 special clinics for children with cardiac conditions, 2 for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services. The August clinics are:

August 1—Litchfield, Madison Park School
August 1—Macomb, St. Francis Hospital
August 7—Hinsdale, Hinsdale Sanitarium
August 8—Effingham, St. Anthony Hospital
August 8—Springfield, St. John's Hospital
August 9—Chicago Heights (Cardiac, St. James Hospital
August 13—East St. Louis, Christian Welfare Hospital
August 13—Peoria, Children's Hospital (St. Francis)
August 14—Alton (Rheumatic Fever), Memorial Hospital
August 15—Rockford, St. Anthony's Hospital
August 15—Tuscola, Community Building
August 16—Evanston, St. Francis Hospital
August 21—Chicago Heights (General), St. James Hospital
August 21—Elmhurst (Cardiac), Memorial Hospital of DuPage Co.
August 22—Bloomington (A.M., General; P.M., Cerebral Palsy), St. Joseph's Hospital
August 23—Chicago Heights (Cardiac), St. James Hospital
August 27—Belleville, St. Elizabeth's Hospital
August 27—Effingham (Rheumatic Fever), St. Anthony Hospital
August 27—Peoria, Children's Hospital (St. Francis)
August 28—Elgin, Sherman Hospital
August 28—Springfield (Cerebral Palsy), Memorial Hospital

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Urology award

The American Urological Association offers an annual award of $1000 (first prize of $500, second prize $300 and third prize $200) for essays on the result of some clinical or labo-

ratory research in urology. Competition shall be limited to urologists who have been graduated not more than ten years, and to hospital internes and residents doing research work in urology.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Roosevelt Hotel, New Orleans, Louisiana, April 28-May 1, 1958.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1957.

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Ultrasonics in medicine

An international conference of ultrasonics in medicine sponsored by the American Institute of Ultrasonics in Medicine, will be held at the Statler Hotel, Los Angeles, California, September 6-7, 1957. John H. Aldes, M.D., 4833 Fountain Avenue, Los Angeles, 29, California, is secretary.

The meeting will cover the biological and physiological principles, as well as the clinical aspects of ultrasonics in medicine. There will also be a round table conference covering all these phases. Participating in the meeting will be representatives from Europe, South America and Japan.

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American Board of Obstetrics and Gynecology

Applications for certification (American Board of Obstetrics and Gynecology), new and reopened, Part I, and requests for re-examination Part II are now being accepted. All candidates are urged to make such application at the earliest possible date. Deadline date for receipt of applications is September 1, 1957. No applications can be accepted after that date.

Candidates for admission to the Examinations are required to submit with their application, an unbound 8 1/2 x 11" typewritten list of all patients admitted to the hospitals where they practice, for the year preceding their application, or the year prior to their request for reopening of their application. This information is to be attested to by the Record Librarian, Superintendent, or Director of the hospitals where the patients are admitted. Current Bulletins outlining present requirements may be obtained by writing to the Secretary, Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio.

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Pan-Pacific Surgical Association

The Seventh Congress of the Pan-Pacific Surgical Association will be held in Honolulu, Hawaii November 14-22, 1957. All members of the profession are cordially invited to attend and are urged to make arrangements as soon as possible if they wish to be assured of adequate facilities.

An outstanding scientific program by leading surgeons with sessions in all divisions of surgery and related fields promises to be of interest to all doctors.

Further information and brochures may be obtained by writing to Dr. F. J. Pinkerton, Director General of the Pan-Pacific Surgical Association, Room 230, Young Building, Honolulu, Hawaii.

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Midwest meeting of the American College of Physicians

In addition to conducting a National Convention yearly, the American College of Physicians sponsors from twenty-five to thirty Regional Meetings in various parts of the United States and Canada; also in Puerto Rico and Hawaii. Many of these Regional Meetings are of an individual State character and are organized and directed by the College Governor of that State. However, in the Midwestern area of the country, the States of Illinois, Indiana, Iowa, Minnesota and Wisconsin have combined and put on as a united effort an annual "Midwest Regional Meeting," the meeting rotating among the various College Governors from that area.

On October 12, 1957, the Midwest Regional Meeting for the first time will be held at Urbana, Illinois under the General Chairmanship of Dr. Charles H. Drenckhahn, College Governor for Southern Illinois. Dr. Norris L. Brookens, of Urbana, is the Chairman of the

Scientific Program. Plans for the Scientific Program call for the presentation of twenty-two papers of twelve minutes each, followed by a three-minute period of discussion from the floor for each paper. Already the Program Committee has collected the titles and abstracts of many offerings and are presently engaged in making selections for the final program, emphasis being placed on original experimental or clinical work. The program will be ready for distribution by September 1.

Non-members of the College in the area who may be interested in Internal Medicine are cordially invited to attend. No registration fee is charged.

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640th USAF Hospital "Call for Reservists"

A call is being issued for former active medical and dental personnel by the 640th USAF Hospital (Reserve).

Newly activated and meeting for the first time this month the squadron has openings in medical and non-medical AFS's to include up to 179 officers and 559 airmen in slots up to the grade of Colonel for officers and Master Sergeant for airmen.

Under the command of Lt. Col. Samuel B. Spira the squadron will train to maintain a fixed medical treatment facility for a 1000 bed USAF Hospital.

As a category "A" Unit, training will include 48 pay periods and a 15 day active duty tour yearly.

Non-prior service nurses are invited to train with the unit and secure a commission in the Air Force Reserve.

All interested personnel are requested to contact M/Sgt. Bilderback at Andover 3-3600, Ext. 658 for more information.

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Disposal of excreta

In 1932, the Rockefeller Foundation began a three year campaign to provide every household with a fly proof pit latrine. Lacking supervision and guidance, many of the latrines have been neglected and are no longer serviceable. Insect breeding and the spread of intestinal helminthiasis are encouraged by the continued though erratic use of this means of excreta disposal since the latrines are no longer insect proof. *Peggy Crooke Fry. Dietary Survey on Rarotonga, Cook Islands. Am. J. Clin. Nut. Jan.-Feb.* 1957.

Of the biological factors involved in the etiology of tuberculosis, nutrition is perhaps the most important. Even before the discovery of the tubercle bacillus the value of a liberal diet in the treatment of tuberculosis was generally recognized. And, conversely, the association of phthisis with malnutrition was apparent. Complete proof of the role of malnutrition in tuberculosis is still lacking but the evidence is convincing. Alton S. Pope, M.D., and John E. Gordon, M.D., Am. J. Med. Sciences, September, 1955.

AT THE EDITOR'S DESK



The majority of this month's press releases deal with papers given at the 106th annual convention of the American Medical Association in New York in June. The new Coliseum proved to be an ideal spot to view the scientific exhibits. Chicago is in dire need of a convention hall of this type. How long are the City Fathers going to procrastinate? No medical convention brings such a high attendance as the AMA and physicians who fail to go are missing a world of medical knowledge.

Newspapers throughout the state carried stories on the talks given at the Convention. One release described the results obtained on 115 eye operations in which a plastic lens was substituted for a removed lens damaged by cataract. This procedure was devised in 1949 by Harold Ridley, a London surgeon. The patients of the American ophthalmologists, who ranged in age from 12 to 80, showed various adverse reactions; the majority were not serious, although four plastic lenses had to be removed. Eleven operations, started as the Ridley technique, had to be converted into conventional extractions because of complications. This news release would be incomplete without a sentence from the final paragraph: "The Ridley operation should be used mainly in cases where only one eye has a cataract so that after operation, both eyes can be used together." This is important because the plastic lens may act as a foreign body.

Gamma globulin injections shorten the course of pityriasis rosea, according to three University of Michigan researchers. They believe their results support the theory of a viral etiology of this disease. Best results occurred when plasma was obtained from the blood of convalescent pityriasis patients.

Dr. Paul Gyorgy, Professor of Pediatrics at the Hospital of the University of Pennsylvania re-emphasized the importance of milk, especially human milk, for the young infant. He questioned the value of early feeding of semi-solid foods because the difference in growth following this plan is not great enough to recommend it routinely. In addition, the sucking reflex may be discouraged. "We should not attempt to make a biting animal out of a sucking animal until the organism is physiologically prepared for biting," he said.

The caption, "Postpartum Mental Illness is not a Separate Disease" appeared in a release stemming from a report by staff members of the New York Hospital—Westchester Division, White Plains, N. Y. Their work is based on a study of 100 women who developed mental illness after delivery and 100 similar patients whose mental disorder was not associated with childbirth. Postpartum psychosis occurs in one out of every 357 pregnancies, accounting for 5 to 7 per cent of all female admissions to mental

(*Continued on page* 46)

NEWS of the STATE



On June 11, Dr. William J. Farley, Peru, addressed the Bureau County Medical Society in Spring Valley on "The Interpretation of the Female Pelvis."

On June 11, Dr. Edward S. Burge, Evanston, assistant professor of obstetrics and gynecology, Northwestern University Medical School, addressed the LaSalle County Medical Society in Ottawa on "Prenatal Care; Treatment of Threatened Abortion; Management of Habitual Abortions." This meeting was arranged by the Committee on Postgraduate Medical Education and Scientific Service.

The Montgomery and Macoupin County Medical Societies were the guests of the Montgomery County Bar Association, June 11, at a dinner meeting in Litchfield.

Dr. John E. Doyle, Ridgeway, has assumed office as president of the Gallatin County Medical Society.

Dr. Glenn W. Chamberlin, Monmouth, was elected secretary of the Warren County Medical Society at a recent meeting. Dr. J. O. Firth, also of Monmouth, is president of the society.

DEATHS

George Richard Bradley*, Jacksonville, who graduated at Barnes Medical College, St. Louis, in 1897, died February 21, aged 87, of strangulated inguinal hernia and arteriosclerosis.

Felicia H. Cienciara*, Oblong, who graduated at the University of Illinois College of Medicine in 1915, died in May 1956, aged 65.

Charles Martin Culver* retired, Bell Gardens, California, formerly of Evanston, who graduated at Jenner Medical College, Chicago, in 1902, died recently, aged 82.

Stephen Alfred Forbes*, Chicago, who graduated at Rush Medical College in 1937, died March 16, aged 47. He was assistant professor of radiology at the University of Illinois College of Medicine; at one time assistant professor of radiology at the State University of Iowa College of Medicine.

Edward M. Friedman, retired, Highland Park, who graduated at Bennett Medical College in 1914, died May 22, aged 68. He was former staff physician for the Metropolitan Life Insurance Company.

Martin Freundlich*, Chicago, who graduated at the Medical College of Virginia, Richmond, in 1945, died May 14, aged 34. He was a member of the staffs of Bethany and Mary Thompson Hospitals.

Lewis L. Haas, Chicago, who graduated at Magyar Királyi Pázmány Petrus Tudományegyetem Orvosi Fakultassa, Budapest, in 1918, died June 2 in an automobile accident near Quebec after attending a medical convention there. He was associate professor of roentgenology at the University of Illinois College of Medicine.

Raymond W. Halpin, Chicago, who graduated at Stritch School of Medicine of Loyola University in 1950, died June 2 as the result of an automobile accident incurred the same day. He was 34. He was with the United States Public Health Service in eastern cities before joining the staff of Mercy Hospital in 1956.

Frank H. Henderson*, Bloomington, who graduated at Hering Medical College, Chicago, 1905, died April 16, aged 76.

Joseph E. Lepke*, Chicago, who graduated at Rush Medical College in 1923, died June 7, aged 60. He was a member of the staff at Jackson Park Hospital.

*Indicates member of the Illinois State Medical Society

Hugh McKenna*, Chicago, who graduated at Rush Medical College in 1903, died in May, aged 82. He was emeritus associate professor of surgery at Northwestern University Medical School.

Gilbert P. Pond, Oak Park, who graduated at Rush Medical College in 1920, died May 20, aged 63. He was a member of the staff of the West Suburban Hospital.

Edward Brewster Pressly, Sparta, who graduated at the Medical College of Georgia, Augusta, in 1950, died in St. Luke's Hospital, St. Louis, December 12, aged 42.

Robert Rodin, Urbana, who graduated at the University of Illinois College of Medicine in 1931, died January 5, aged 49, of leukemia. He was a member of the health service staff, University of Illinois, where he was assistant professor of hygiene.

Isador Simon Trostler*, Chicago who graduated at the University of Nebraska College of Medicine, Omaha, in 1904, died March 10, aged 87, of hypostatic pneumonia and arterio-sclerotic heart disease.

*Indicates member of Illinois State Medical Society.

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EDITOR'S DESK (Continued)

hospitals. Symptoms and the course of the disease were no different in either group. In their opinion, the release states. "There are some persons who react abnormally to every major change in life whether it be adolescence, college, marriage, childbirth, promotion, or aging. It would be impossible to say there is a college psychosis simply because many young people develop acute mental illness during their college days."

In another release, Dr. H. R. Brinkman of Los Angeles was quoted as saying that the family doctor can and should treat juvenile delinquency. His studies of families of delinquent children unearthed many ways in which parents "struggling with their own emotional problems and against their own antisocial impulses, unwittingly and unconsciously provoke, evoke, and even encourage delinquent behavior in certain of their children."

Many of the AMA releases confirmed old concepts. For example: "Improvement of symptoms, which are sometimes striking, occurred among patients with chronic respiratory disorders who gave up smoking, two University of Virginia physicians have reported." In another release, a Kansas general practitioner concluded that over-indulgence in good food is the most common cause of obesity. He recommended a natural diet high in proteins and fat and low in carbohydrates, but stressed the fact that the patient must be motivated to lose weight. It is here that the physician must reach deep into his bag of tricks to achieve the goal.



By changing the attitude of the emotional dermatologic patient, 'Thorazine' facilitates the management of the patient and the treatment of skin disorders. The patient becomes less insistent and frantic, and accepts her affliction philosophically. 'Thorazine' does not cure skin diseases but, according to Cornbleet and Barsky,[1] is a "most useful adjuvant to dermatologic therapy" in patients with an emotional background of tension, apprehension, excitement, anxiety and agitation.

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"can be to the dermatologist what the anesthetist is to the surgeon."[1]

Smith, Kline & French Laboratories, Philadelphia

1. Cornbleet, T., and Barsky, S.: The Role of the Tranquilizing Drugs in Dermatology, presented at 115th Annual Meeting of Illinois State Medical Society, May 19, 1955.

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

BOOK REVIEWS

BASIC FOUNDATIONS OF ISOTOPE TECHNIQUE FOR TECHNICIANS by Willard C. Smullen, M.D., F.A.C.R., Radiologist in Charge, St. Mary's Hospital, Decatur, Illinois; Paul C. Aebersold, M.A., Ph.D. Director, Isotope Extension, United States Atomic Energy Commission, Oak Ridge, Tennessee; James E. Durlacher, B.S., Physicist, Indiana University Hospitals and Consultant, Isotope Department, Veterans Hospital, Indianapolis, Indiana; James P. Aldworth, Nuclear Instrument and Chemical Corporation, Chicago, Illinois; G. W. Morgan, Ph.D., Chief, Radiological Safety Branch, Isotope Extension, United States Energy Commission, Oak Ridge, Tennessee; Donalee Tabern, Ph.D., Head, Radiopharmaceutical Division, Abbott Laboratories, Chicago, Illinois; J. W. Little, Jr., M.D., Radiologist and Chief of Isotope Section, Department of Radiology, St. Mary's Hospital, Decatur, Illinois; Edward Cook, M.D., Radiologist, Department of Radiology, Decatur and Macon County Hospital, Decatur, Illinois. First edition, 163 pages, Charles C. Thomas Company, Springfield, Illinois, 1956. $4.75. 54 Figures, 7 Tables.

This concise text of technique is valuable not only for the technician in his daily routine of isotope handling, but also would be an excellent aid for those physicians not performing isotope procedures to decide whether they want to undertake such studies.

The actual technique involved is explained in adequate detail to enable anyone to carry out the procedure. In addition, there is a moderate amount of theory accompanying each subject and, while this is certainly not a complete text in this regard, it does represent an excellent introduction to the subject.

The terminology used throughout is representative of the actual wordage used in the department of the author. This includes the clinical and trade names of the isotopes as well.

An excellent chapter on protection is included with very clear cut statements as to currently accepted values for radiation tolerance. This book satisfies a need for an introduction to isotope diagnosis and therapy for the physician who has no contact with it whatsoever, and also serves as an excellent manual for the technician.

C.R.M.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

SIGNS AND SYMPTOMS: Applied Pathologic Physiology and Clinical Interpretation. Edited by Cyril Mitchell MacBryde, A.B., M.D., F.A.C.P., Associate Professor of Clinical Medicine, Washington University School of Medicine. Third Edition. 191 illustrations and 6 color plates. J. B. Lippincott Company, Philadelphia and Montreal.

(*Continued on page* 46)

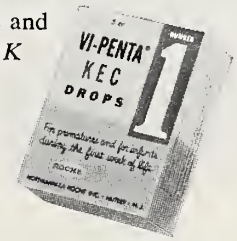
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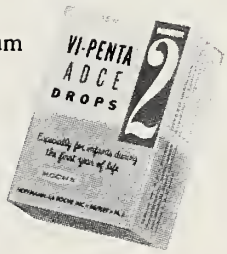
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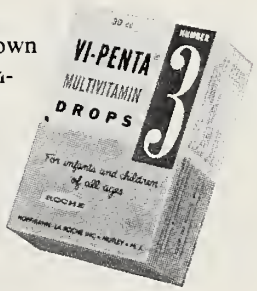
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Vi-Penta #2—Just 0.6 cc daily provides — in optimum amounts—vitamins A, D, C and E, especially important in the first year of life. When B factors are desired, Vi-Penta #3 may be used. Supplied in 15 cc and 50 cc bottles.



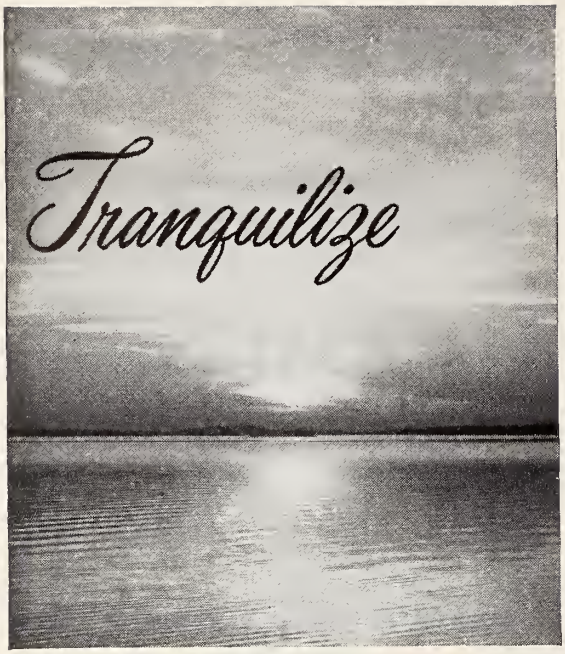
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PRACTICE OF MEDICINE. Edited by Jonathan Campbell Meakins, C.B.E., M.D., LL.D., D.Sc. Sixth edition. 318 illustrations, including 4 in color. The C. V. Mosby Company, St. Louis. $16.00.

MARTIUS' GYNECOLOGICAL OPERATIONS. With Emphasis on Topographic Anatomy. Translated and edited by Milton L. McCall, M.D., F.A.C.S., professor and head, Department of Obstetrics and Gynecology, Louisiana State University School of Medicine, New Orleans, and Karl A. Bolten, M.D., formerly instructor, Department of Obstetrics and Gynecology, Louisiana State University School of Medicine, New Orleans. 450 illustrations by Kathe Droysen. Little, Brown and Company, Boston and Toronto. $20.00.

A TEXTBOOK OF HISTOLOGY. By Alexander A. Maximow, late professor of anatomy, University of Chicago, and William Bloom, professor of anatomy, University of Chicago. Seventh edition. 1082 illustrations, 265 in color, on 631 figures. W. B. Saunders Company, Philadelphia and London, $11.00.

A VISIT TO THE HOSPITAL. By Francine Chase. Pictures by James Bama. Prepared under the supervision of Lester L. Coleman, M.D. Introduction by Flanders Dunbar, M.D. Grosset & Dunlap, New York. $1.50.

A WOMAN DOCTOR LOOKS AT LOVE AND LIFE. By Dr. Marion Hilliard. Doubleday & Company, Inc., Garden City, New York. $2.95.

ALCOHOLISM. A Treatment Guide for General Practitioners. By Donald W. Hewitt, M.D. Lea & Febiger, Philadelphia. $3.00.

REGULATION AND MODE OF ACTION OF THYROID HORMONES. Ciba Foundation Colloquia on Endocrinology. Volume 10. Editors for the Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Elaine C. P. Miller, A.H.-W.C., A.R.I.C., 114 illustrations. Little, Brown and Company, Boston. $8.50.

HUTCHISON'S CLINICAL METHODS. By Donald Hunter, M.D., F.R.C.P., Physician to the London Hospital and R. R. Bomford, D.M., F.R.C.P., Physician to the London Hospital. 13th edition. J. B. Lippincott Company. $6.00.

THE TREATMENT OF BURNS. By Curtis P. Artz, M.D., F.A.C.S., Lt. Col., MC, USA (Ret). Formerly, Director of Surgical Research Unit, Brooks Army Medical Center, Fort Sam Houston, Texas; Presently, associate professor of surgery, University of Mississippi Medical Center, Jackson, Miss., and Eric Reiss, M.D., American Cancer Society Scholar and instructor in Medicine, Washington University School of Medicine, St. Louis, Missouri. 250 pages. 199 illustrations on 105 figures. Illustrations by Burr Bush. W. B. Saunders Company, Philadelphia and London, $7.50.

VEGETABLE OILS IN NUTRITION—with special reference to unsaturated fatty acids. By Dorothy M. Rathmann., Ph.D., Multiple Fellowship of Corn Products Refining Company, Mellon Institute, Pittsburgh 13, Pa. Published by the Corn Products Refining Company, 17 Battery Place, New York 4, New York.



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(*Continued on page* 50)

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Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Ann. New York Acad. Sc. 67:701, May 9, 1957.

2 "Since it [meprobamate—'Miltown'] does not cloud consciousness or lessen intellectual capacity, it can be used . . . even by those busily occupied in intellectual work."

Keyes, B. L.: Pennsylvania M. J. 60:177, Feb. 1957.

3 "...the patient never describes himself as feeling detached or 'insulated' by the drug ['Miltown']. He remains completely in control of his faculties, both mental and physical . . ."

Sokoloff, O. J.: A.M.A. Arch. Dermat. & Syph. 74:393, Oct. 1956.

4 "It ['Miltown'] . . . does not cloud the sensorium, and has a helpful somnifacient effect devoid of 'hangover'."

Kessler, L. N. and Barnard, R. D.: M. Times 84:431, April 1956.

5 "In anxiety and tension states, meprobamate relaxes without dulling cortical function to the same extent as the commonly-used barbiturates."

Rindskopf, W., Ravreby, M., Gutenkauf, C. and Sands, S. L.: J. Iowa M. Soc. 47:57, Feb. 1957.



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The crossing of the curves: tuberculosis and lung cancer

By Edward Kupka, M.D., and Lester Breslow, M.D., Diseases of the Chest, January 1957.

The decline in tuberculosis mortality and the sharp rise in lung cancer mortality have led to a "Crossing of the Curves". By 1950 in California primary cancer of the trachea, bronchus and lung was causing more deaths than tuberculosis among persons 65 years of age and over. By 1954 lung cancer deaths exceed deaths from all forms of tuberculosis in the whole population.

Since 1930 tuberculosis mortality has dropped to one-tenth of its rate at that time. The respiratory cancer rate meanwhile, has more than trebled with lung cancer comprising an ever larger proportion of the total.

Death Rates Per 100,000 Population, California

	1930	1954
Tuberculosis, all forms	99.1	9.8
Tuberculosis, respiratory	88.4	9.0
Cancer, respiratory system	5.2	17.9

FACTORS IN REDUCTION OF TUBERCULOSIS MORTALITY

Two groups of factors have contributed to the decline in tuberculosis mortality. First are the medical developments and second the general improvement in standard of living. Together they have accounted for a steady decline in tuberculosis mortality. The addition of antibiotics and other potent drugs to the therapeutic resources has accelerated the rate of decline. The annual incidence rate has likewise decreased, but at a less rapid rate. The tremendous expansion of X-ray survey programs has increased the proportion of known tuberculosis, but since in the U.S. there are still an estimated 150,000 unreported and largely undiagnosed and unsuspected persons with active tuberculosis diagnostic activities and propaganda for more frequent X-ray films must continue unabated.

A gradual change in the differential diagnostic problem is evident. In past years, tuberculosis was found more commonly on the chest film than all other serious chronic lung conditions combined. Today lung cancer and lung suppuration challenge tuberculosis in frequency.

FACTORS IN THE INCREASE OF LUNG CANCER MORTALITY

Because so few patients with lung cancer survive even with treatment, the age-adjusted mortality rate remains the best measure of the disease. This rate is still increasing rapidly. Improved methods of diagnosis account in part for the rise in lung cancer deaths. However, since 1940, the mortality rate for men in California has increased 147 per cent while that for women has been only 29 per cent.

Three sets of factors have been suggested to account for the increase and present data indicate that each of the three play a role in the development of lung cancer. Many studies have disclosed a greater frequency of cigarette smoking, especially heavy cigarette smoking, among patients with lung cancer as compared with controls. Several occupations have been incriminated, particularly those involving exposure to certain metallic substances or fumes. In this country carcinogenic substances have been isolated from polluted city air.

In evaluating the carcinogenic effects of environmental agents one must bear in mind the time factor. The evidence suggests that environmental factors lead to human cancer only after many years of exposure. Hence, the rise in lung cancer mortality during the period 1930-1960 may reflect environmental factors during the first half of this century. Likewise the environmental changes during recent years—e.g., vast increases in cigarette smoking among young people of both sexes, entry of hundreds of thousands of persons into such occupations as welding, the heavy air pollution of certain cities—may portend a continuing increase in lung cancer mortality during the latter half of this century.

TUBERCULOSIS AND LUNG CANCER MORTALITY PATTERNS

The male predominates in mortality from both conditions. The ratio is about three to one in the case of tuberculosis, and five to one in lung carcinoma.

Tuberculosis, formerly a disease of adolecents and young adults predominantly, has now become a disease of middle aged and older persons predominantly. Lung cancer, too, is a disease of the middle and later years of life.

Tuberculosis is especially prevalent in slum areas, among poorly nourished persons, and among those living in contact with infectious

(*Continued on page* 54)

Current Practices in Dietary Management of

Infant Allergies

Infants are not born hypersensitive but may develop hypersensitivity to foodstuffs shortly after birth. The earliest sensitizations are likely to be to milk, wheat, eggs and orange juice, with which contact is established early in life. Heredity is usually a dominant factor in the tendency of infants to develop allergy. Infants with a family history of both paternal and maternal allergy tend to develop clinical symptoms earlier than those with unilateral inheritance. Both the allergen and the symptom in the infant may be different from those of the father or mother.

Allergic disorders of infants include gastrointestinal disturbances, infantile eczema, urticaria and asthma. Gastrointestinal allergy may be manifested by vomiting, colicky abdominal pain and diarrhea. Allergic dermatitis may be evidenced by wheal-like cutaneous reactions which may develop into exudative lesions over the scalp, face and body. A systemic food hypersensitivity may produce an asthmatic response manifested by dyspnea and wheezing, although infection is usually associated with this type of response.

Common treatments include avoidance of the allergen, desensitization, antihistaminics and, in the presence of infection, antibiotics. Infants sensitive to the proteins of cow's milk whey may be fed human, goat or mare's milk reinforced with KARO® Syrup. Casein-sensitive infants may be offered soybean milk or amino acid mixtures reinforced with KARO Syrup.

The same problems of infant feeding recur from generation to generation, but solutions may differ with each era. The carbohydrate requirement for all infants is as completely fulfilled by KARO Syrup today as a generation ago. Whatever the type of milk adapted to the individual infant, KARO Syrup may be added confidently because it is a balanced mixture of low molecular weight sugars, readily miscible, well tolerated, palliative, hypo-allergenic, resistant to fermentation in the intestine, easily digestible, readily absorbed and non-laxative. KARO is readily available in all food stores.

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Age Months	Fluid Milk Fluid Oz.	Water Oz.	KARO Tbsp.	Each Feeding Oz.	No. of Feedings in 24 Hrs.	Total Calories
Birth	10	10	2	3	6	320
1	12	13	2½	4	6	390
2	15	13	3	4½	6	480
3	17	9	3	5	5	520
4	20	11	3½	6	5	610
5	23	11	4	6½	5	700
6	26	10	4	7	5	760
7	28	11	3	7½	5	740
8	30	11	2½	8	5	750
10	32	9	2	8	5	760

EVAPORATED GOAT'S MILK FORMULAS

Age Months	Weight Lbs.	Evap. Goat's Milk Oz.	Water Oz.	KARO Tbsp.	Each Feeding Oz.	No. of Feedings in 24 Hrs.	Total Calories
Birth	7	6	12	1	3	6	290
1	8	8	16	2	4	6	395
2	10	9	14	3	4½	5	520
3	12	10	15	3½	5	5	590
4	14	12	18	4	6	5	695
5	16	12	21	4	6½	5	695
6	17	13	22	4	7	5	730
7	18	14	21	3	7	5	710
8	19	15	20	2	7	5	690
10	21	16	16	1	8	4	730

LIQUID SOY MILK FORMULAS

Age Months	Evap. Milk Fluid Oz.	Water Oz.	KARO Tbsp.	Each Feeding Oz.	No. of Feedings in 24 Hrs.	Total Calories
Birth	6	12	2	3	6	380
1	8	16	3	4	6	532
2	9	14	3	4½	5	576
3	10	15	3½	5	4	650
4	12	18	4	6	5	768
5	12	21	4	6½	5	768
6	13	22	4	7	5	768
7	14	21	3	7	5	796
8	15	20	2	7	5	780
10	16	16	1	8	4	764

DRIED SOY MILK FORMULAS

Age Months	Dry Milk	Water Oz.	KARO Tbsp.	Each Feeding Oz.	No. of Feedings in 24 Hrs.	Total Calories
Birth	6	20	2	3	7	360
1	8	22	2	4	6	440
2	9	24	2½	4	6	510
3	10	29	3	6	5	580
4	12	33	3½	7	5	690
5	13	33	3½	7	5	730
6	14	33	3½	7	5	740
7	14	33	2½	7	5	710
8	15	33	2	7	5	720
10	15	33	2	8	4	720



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LUNG CANCER (Continued)

cases. Lung carcinoma is more scattered in their distribution; housing and nutritional factors seem to play little, if any, role.

DIAGNOSIS AND TREATMENT

Ordinarily, an X-ray film of the chest is the earliest method of detecting either disease. However, certain forms of tuberculosis and carcinoma cannot be easily differentiated on the film. In fact, the X-ray film usually cannot be considered definitively diagnostic unless supplemented by laboratory methods and histologic examination. In the case of tuberculosis, the demonstration of tubercle bacilli is definitive. In the case of carcinoma, biopsy or cytologic examination may give the answer. Every clinically silent lesion casting shadow on the chest X-ray film must have tuberculosis and carcinoma ruled out before any other diagnosis can safely be made. Resection of lung containing a small cancerous nodule in a person in apparently good health represents a triumph of preventive medicine.

The organization and technical machinery originally set up for tuberculosis can be and is being used increasingly to attack the problem of cancer of the lung. The same skills are necessary for diagnosis and treatment. As time goes on the epidemiology of cancer of the lung will assume a larger importance, and this will concern all health departments.

EPIDEMIOLOGIC APPROACHES TO CONTROL

The final conquest of tuberculosis depends upon preventing the transmission of infection from one person to another. Elimination of slums, the examination of every contact of tuberculosis cases, the X-ray film examination of every hospital and prison admission and the isolation of infectious persons will cut so many chains of person-to-person infection that virtual disappearance of the disease may be hoped for.

The factor of resistance is a very important one in tuberculosis. Improvement in general health and lessened crowding make transmission less likely. A significant factor in tuberculosis control is alcoholism which reduces resistance and increases chances of transmission.

No dependable data are at hand regarding the role of smoking in tuberculosis. However, re-

(*Continued on page* 56)

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A Better Antihypertensive

. . . because among all Rauwolfia preparations Rauwiloid (alseroxylon) is maximally effective and maximally safe . . . because least dosage adjustment is necessary . . . because the incidence of depression is less . . . because up to 80% of patients with mild labile hypertension and many with more severe forms respond to Rauwiloid alone.

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. . . because Rauwiloid's *nonsoporific* sedative action relieves anxiety in a long list of unrelated diseases not necessarily associated with hypertension . . . without masking of symptoms . . . without impairing intellectual or psychomotor efficiency.

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After full effect one tablet suffices.

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In moderate to severe hypertension this single-tablet combination permits long-term therapy with dependably stable response. Each tablet contains 1 mg. Rauwiloid and 3 mg. Veriloid. Initial dose, 1 tablet t.i.d., p.c.

Rauwiloid®+ Hexamethonium

In severe, otherwise intractable hypertension this single-tablet combination provides smoother, less erratic response to hexamethonium. Each tablet contains 1 mg. Rauwiloid and 250 mg. hexamethonium chloride dihydrate. Initial dose, ½ tablet q.i.d.

Riker LOS ANGELES

LUNG CANCER (Continued)

spiratory trauma, which is inevitable in a coughing, compulsive smoker, probably decreases the ability of pulmonary tissue to defend itself against the tubercle bacillus. On the other hand, overwhelming epidemiological evidence now indicates that cigarette smoking is an important causative factor in lung cancer.

Further studies should be carried out. Even more needed is epidemiologic study of air pollution and occupations as causative factors in lung cancer. It is conceivable that cigarette smoking may have been the most important causative element in the increasing mortality from lung cancer up to the present time, but that other environmental factors may be active and more so in the future. Laboratory studies should be carried out to isolate the specific substances in the environment and the mechanics of action.

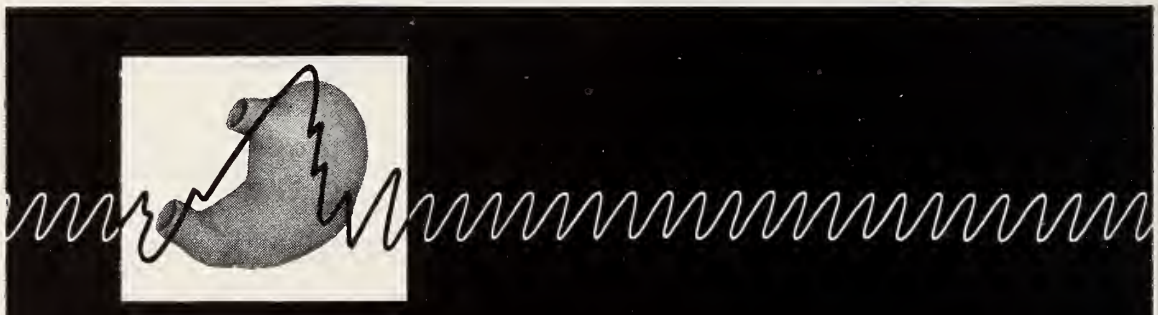
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Girl babies seem to be healthier than boy babies: In 1954, says Health Information Foundation, the mortality rate for male infants was 28 percent higher than for female infants.

Broader knowledge

Some spokesmen among the educators have suggested de-emphasis of scholarship. This, it seems to us, should be left last. When we plead for broader knowledge and better use of the English language on the one hand, how can we devaluate the humanities and preparation for a creditable place in a learned profession, on the other? Those of us who read and grade our students' examination papers are startled to note how few of them write well, and how still fewer express themselves clearly or even can spell. Upon reviewing the histories and physical examinations that some of the interns and residents write upon our hospital records, we note they often do not see what they are looking at nor properly interpret what they find. Intellectual curiosity often appears to be eclipsed by mere fulfillment of time requirements and the passing, after a fashion, of examinations and board specifications. *Editorial. De-emphasis of Scholarship? Rocky Mountain M.J. March* 1957.

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A poor soldier

As the tram car fibrillated its way along High Street, I stole another glance at the pair sitting opposite me. The mother, tight-lipped and forbidding, stared fixedly into space. By her side, completely enveloped from head to waist in a large pillow case, sat a small child. Davy Crockett had, I knew, been consigned to the limbo of yesterday's heroes; space men were, on the authority of my youngest, quite outre. What this latest costume was meant to resemble I couldn't diagnose - the Ku Klux Klan perhaps. A grimy hand tugged at the mother's dress. "Are we there yet, Ma?" a plaintive voice wailed. No reply was forthcoming and the voice trailed off into a dismal silence. Ghost riders of the sky, I thought, or Roy Rogers in disguise. I rose as we came to our infirmary and at the same time the little figure was jerked upright and hustled off the tram. The conductress didn't look twice - the infirmary run was her regular route. As I walked up the drive I saw them disappearing ahead of me into the casualty entrance. By chance I was called there a short while later. The mother stood grimly over a small boy, now divested of his costume, while a perspiring house surgeon and a nurse pulled and tugged. As a utensil, it has its uses but headgear was certainly not one of them. "He was playing at soldiers." said the mother not without a certain somber satisfaction. *In England Now. Lancet, Sept.* 15, 1956.

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However successful our treatment of tuberculosis in children and young adults may be, unless we control the disease in the higher age groups we shall be a long time reducing the incidence of the disease in the population. The active cases in elderly men and women are going to form the hard core of infection in the community that may give rise to local epidemics of acute cases among the young contacts. It behooves us, therefore, to discover, treat, and if necessary isolate these dangerous old men and women and to do all we can to protect our children and young adults from the risks to which they are exposed. F.R.G. Heaf, M.D., J. Royal Inst. Pub. Health and Hygiene, November, 1955.



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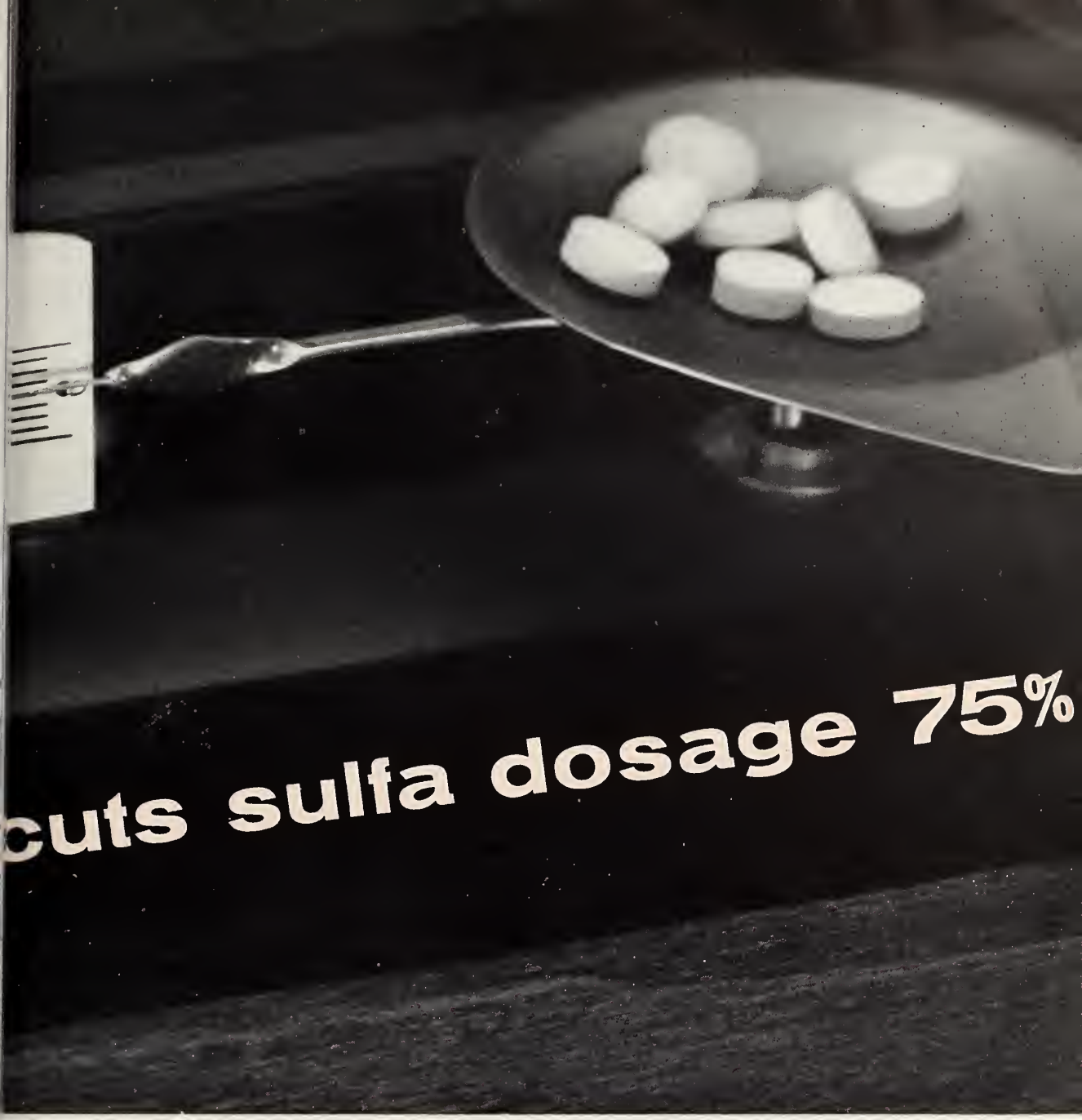
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1. Boger, W. P.; Strickland, C. S. and Gylfe, J. M.: Antibiot. Med. & Clin. Ther. 3:378 (Nov.) 1956.

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Lederle

Increased remuneration

Under the government's interim adjustment, all consultants and senior hospital medical officers will have a 5 per cent rise in remuneration from May 1. This will give the largest money increases to the specialists who have the largest N.H.S. incomes; and, since the main purpose of the interim adjustment should have been to give help where it is most acutely needed, we regret that the 1,200,000 pounds provided for specialists does so little for the junior who, unlike many of his elders, is gaining little or nothing from the budget's surtax changes. Perhaps more attention can be paid to need in deciding on the distribution of the 5 per cent rise for general practitioners. This adds 2,500,000 pounds to the total sum available to them as a group, and the Minister of Health is prepared to discuss with their representatives the best way of dividing it. The next special representative meeting of the British Medical Association may have to decide, among other things, whether acceptance of this interim award is compatible with the "planned withdrawal" from the National Health Service which the B.M.A. council has proposed as a means of exercising pressure on the government. We have already stated our opinion that the only kind of withdrawal they would in fact be justified in considering is permanent resignation from the service—the possibilities of which could be explored while accepting the interim adjustment and co-operating with the Royal Commission. The policy of direct action has won some victories and, for all we know, it might win still more. But their cost, though intangible, is likely to outweigh the gain; and we earnestly hope that the representatives will now feel that they can safely take the longer view. *Annotations. Lancet, April 27, 1957.*

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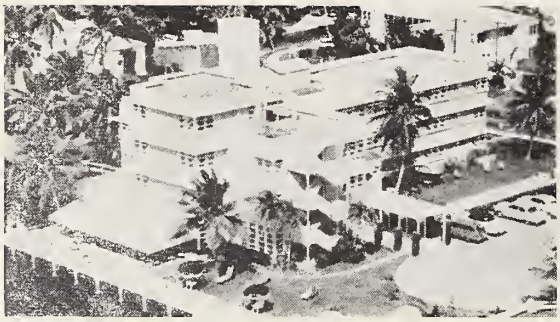
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Federal Council on Aging

In 1956 the President established a Federal Council on Aging to advise him on the overall aspects of the problem in areas where Federal government activity seems appropriate. A special staff on aging has been set up in the office of the Secretary of Health, Education, and Welfare. The Surgeon General of the Public Health Service has assigned a small group of staff members to work with state and local health departments on problems of aging, and the Center for Aging Research has been established at the National Institutes of Health to stimulate research activity by university and other groups. It is hoped that a number of large centers attached to universities can be developed during the next few years to undertake interdisciplinary research and training in gerontology. The concept is that such centers would extend outside the parent university to include other educational institutions in the vicinity and other public and private organizations devoted to the furtherance of public health and to the operation of community activities for older people. The research functions of the centers would be eligible for support from the research grant funds administered by the National Institutes of Health, with the service activities financed from other sources, primarily or entirely non-Federal. *G. Halsey Hunt, M.D. Research in Aging. Med. Ann. District of Columbia, April* 1957.

‹ ›

Isoniazid in acne

Isoniazid has been given to patients whose acne had not responded to conventional therapy such as X-ray, carbon dioxide slush, or ultraviolet light. While we did not use any controls, and the number of cases is not statistically significant, nevertheless the response of those patients who did benefit strongly suggests that such response was due to isoniazid. We noticed that the patients who benefited were those whose acne had an appreciable erythematous component. The drug did not appear to prevent comedo formation nor did it have much effect on deep cysts. However, we feel isoniazid is a valuable adjunct in the treatment of selected cases of acne. *Raymond Allen Osbourn, M.D. Isoniazid in the Treatment of Acne Vulgaris. Arch. Dermat. Jan.* 1957.

Meat...

and Dietotherapy in Cirrhosis of the Liver

A fundamental requirement to maintain compensation in atrophic or postnecrotic cirrhosis of the liver is the provision of a well-organized diet adequate in calories and biologically balanced protein.[1]

Many authorities recommend that the diet should supply 1.2 to 2.0 grams of protein per kilogram of desirable body weight, except for the patient with impending hepatic insufficiency, who is intolerant to large amounts of protein. Moderate amounts of fat are permissible in order to make the diet more taste-acceptable. There is no valid evidence that supplementing the adequate diet with choline, methionine, other lipotropic agents, or vitamins has therapeutic significance.[2]

An acceptable diet for a patient whose normal weight approximates 70 kilograms provides 110 to 120 grams of protein, 225 to 250 grams of carbohydrate, 80 to 90 grams of fat, and 2000 to 2300 calories.[1] The foods selected should assure an adequate intake of vitamins and minerals.

Lean meat is particularly competent in contributing to the patient's needs for protein, B vitamins, and the minerals iron, potassium, phosphorus, and magnesium. Its appeal to the palate helps maintain food interest. At least 8 ounces daily should be included in the dietary program in this disease.[3]

---

1. Snell, A. M.; Kark, R.; Butt, H. R.; Sborov, V., and Jones, C. M.: Panel on Liver Diseases, J.A.M.A. *158*:116 (May 14) 1955.
2. Gabuzda, G. J.: Clinical and Nutritional Aspects of Lipotropic Agents, with Special Reference to Their Role in the Pathogenesis and Treatment of Fatty Cirrhosis of the Liver, Report to the Council on Foods and Nutrition, J.A.M.A. *160*:969 (Mar. 17) 1956.
3. The Committee on Dietetics of the Mayo Clinic: Mayo Clinic Diet Manual, ed. 2, Philadelphia, W. B. Saunders Company, 1954, pp. 39-41.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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‹ ›

Bad for the brain

The wandering physician is a familiar figure in history. Hippocrates, Galen, Paracelsus, and others were never very long in one place. The founders of the Edinburgh Medical School drew their inspiration from Leyden; and Sir William Osler, himself a mobile professor, was wont to say that permanence of residence, good for the pocket, was bad for the brain. *Douglas Guthrie, M.D. Harvey in Space and Time. Brit. M.J. March* 9, 1957.

‹ ›

All diabetics should have annual chest X-rays. Any sudden increase in insulin requirements or loss of weight, even thought it appears voluntary, should be followed by a roentgenographic examination of the chest. By earlier diagnosis the prognosis of tuberculosis in the diabetic will be immeasurably improved. Treatment of both diseases must be aggressive. Robert H. Joelson, M.D., Henry Dolger, M.D., J. of Mt. Sinai Hosp. of N.Y., July-Aug. 1956.



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1. Weil, L. L.: J. Florida Acad. Gen. Pract. 4:9 (July) 1954. 2. Williams, Henry L.: J. Michigan State Med. Society 51:572-576 (May) 1952.

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‹ ›

A common grievance

It is a common grievance that whatever you like is bad for you. This is the complaint that attaches itself to the pleasures of wine, women, and gluttony. But sleep is an exception. Here, at last, is one thing people like that is truly good for them. *Editorial. J. Student A.M.A. Jan.* 1957.

Tonsils and sinusitis

It is said that 35 per cent of all children have some degree of sinusitis. The maxillary and posterior ethmoid sinuses are most significantly involved. Reports from a middlewestern clinic revealed that 55 per cent of all children examined for removal of adenoids and tonsils had some degree of sinusitis. In other areas, 25 per cent of all children with paranasal sinus disease were found to have allergic rhinitis, and 70 per cent of the children having allergic rhinitis also had some degree of sinusitis. *C. M. Kos, M.D. Relation of Adenoids and Sinusitis to Otologic Disease. Texas J. Med. June* 1956.

‹ ›

All the wild ideas of unbalanced agitators the world over in their ignorant and pitiable quest for happiness through revolution, confiscation of property, and crime cannot overthrow the eternal truth that the one route to happiness through property or government is over the broad and open highway of service. And service always means industry, thrift, respect for authority, and recognition of the rights of others.

—*W. G. Sibley*

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Preconception dietary habits

A comparative study was made of the preconception dietary habits of 51 women who had had histories of habitual abortion, with those of a group of women who had successful pregnancies. In the groups studied, the average dietary intake did not differ statistically, except in the case of thiamine. The average consumption of this nutrient was somewhat higher statistically in the group of women having successful pregnancies. The average number of nutrients provided in adequate amounts in the individual diets of this group also was greater. The women with histories of habitual abortion were classified into three groups on the basis of their average protein consumption. It was found that after attending the clinic, the ratio of abortions to the number of pregnancies was lower for the group of women ingesting a high protein diet, which was found also to be generally excellent in other nutrients. It appears that women in a good nutritional state are more likely to respond to the overall management of habitual abortion than the more poorly nourished. *Anne Bourquin and Roberta Bennum. The Preconception Diet of Women who Have Had Unsuccessful Pregnancies. Am. J. Clin. Nut. Jan.-Feb.* 1957.

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And why not?

A California OB man collects cigar bands as a hobby. His record to date is a total of 18,000. *Capsulets. New Physician. March* 1957.

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The best rules to form a young man are: to talk a little, to hear much, to reflect alone what has passed in company, to distrust one's own opinions, and value others' that deserve it.

—*Sir W. Temple*

‹ ›

Tuberculosis is rapidly being brought back — literally and figuratively — into general medicine and its treatment is no longer confined to isolated, outlying sanatoria. Thoracic surgery, with its requirements of highly skilled surgeons, anesthesia, blood banks, specialized techniques and equipment, started this process, and the chemotherapy of the antimicrobal era has hastened it. Irving J. Selikoff, M.D., J. of Mt. Sinai Hosp. of N.Y., July-August, 1956.

‹ ›

There is a kind of dictatorship that can come about through a creeping paralysis of thought, readiness to accept paternalistic measures by government, and along with those measures come a surrender of our own thought over our own lives and our own right to exercise the vote. The free system gives the right to every citizen to do something for himself. Because he has the right, the opportunity is always there.

—*Dwight D. Eisenhower*

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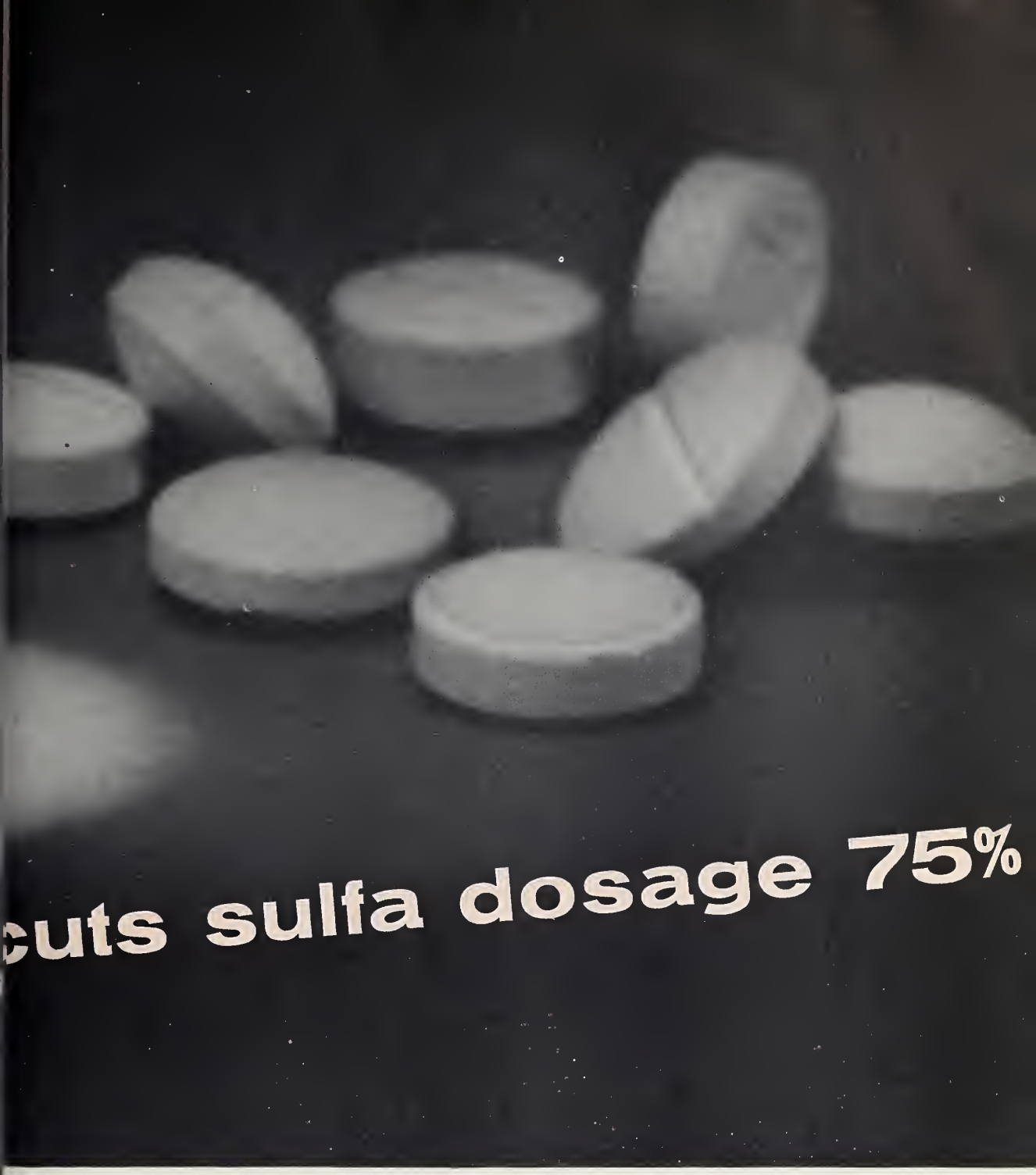
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(1) Boger, W. P.; Strickland, C. S. and Gylfe, J. M.: Antibiot. Med. & Clin. Ther. 3:378 (Nov.) 1956.

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The Month in Washington



Washington, D. C. — The economy drive to the contrary notwithstanding, health spending by the Department of Health, Education, and Welfare for the fiscal year that began this July already is assured of surpassing last year's record by some $33 million. This assumes, of course, that no further requests will be made by HEW for supplemental funds, a practice common in government for many years.

Research programs were the most favored by legislators, many of whom spoke out against federal spending by other agencies. But when the health budget came up for debate, the economy oratory subsided.

In only one instance was a health program cut back. And to the surprise of many, it occurred in the Senate which traditionally restores budget cuts originating in the House. A sum of $45 million was voted, instead of the House-approved $50 million, for grants to states for sewage treatment works construction. But then the Senate wrote in language permitting states to get their maximum allotments a full year after the fiscal year ends.

The Hill-Burton hospital construction program received $3.8 million less than last year but only because the administration asked for $121.2 million instead of the $125 million appropriated last year.

The National Cancer Institute received the largest dollar increase of any health item in the budget. The increment was $8 million over last year. The administration had asked for $48.4 million, the House voted $46.9 million, and the Senate raised this to $58.5. It was fully compromised at $56.4 million.

Congress obviously agreed with the views expressed by the Senate Appropriations Committee: " . . . the committee is fully aware that it is providing funds for cancer research, the outcome of which is unknown. On the judgment of those who are scientifically most competent, the committee is fully willing to risk the investment on the ground that the chance of a big payoff is a reasonable one. Such risks are inherent in research."

The Institute of Arthritis and Metabolic Diseases fared well, too, getting a total of $20,385,000 compared with last year's $17,885,000. And the Senate Committee charged the institute with taking leadership in research on effects of radiation on the human organism.

The Mental Health Institute's spending has been going steadily upward, and this year it was given another boost with a final appropriation of $39,217,000, an increase of about $4 million. Other research totals for the current year: National Heart Institute, $35,936,000; Neurology and Blindness Institute, $21,387,000; Allergy and Infectious Disease Institute, $17,400,000.

On only one score did the research advocates lose out. The House view prevailed in conference on the setting of a 15% ceiling on additional overhead costs allowed schools and other institutions getting federal grants. This question which drew considerable attention in hearings is likely to be reopened. Congress wants a General

(*Continued on page 28*)



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1. Weil, L. L.: J. Florida Acad. Gen. Pract. 4:9 (July) 1954. 2. Williams, Henry L.: J. Michigan State Med. Society 51:572-576 (May) 1952.

WASHINGTON (Continued)

Accounting Office study by the end of this year.

In voting a $5 million increase (to $22,592,-000) for general public health assistance to the states, Congress was reaffirming its support of helping local health departments increase their professional staffs and broaden their services. The Senate Committee report contained this significant language:

" . . . with a population increase of more than 20 million during the past decade, there are no more organized health departments than there were 10 years ago. This means that 18 million people are living in areas with no full-time organized community health services, and millions more live in areas where such services are only fragmentary."

A few days later, the Public Health Service announced plans for a broad survey of rural health needs, particularly in sparsely settled areas. It picked for its first study Kit Carson County, Colo., an area known for its scattered farm population, low income level and adverse climatic conditions.

The President has signed into law a two-year revision of the doctor draft law permitting selective call-up of physicians to age 35 if they were deferred from regular draft service to complete professional training . . . The poliomyelitis vaccine act expired July 1 with all but $400,-000 of $53.6 million taken up by states for inoculation programs. An estimated 29 million children and pregnant women received 70 million injections . . . The Public Health Service has conferred with the American Medical Association on medical manpower plans in event of an epidemic of the new Far East influenza . . . The National Library of Medicine no longer is lending books and other material over the counter to individuals; requests must be channeled through other libraries . . . The administration bill on federal workers health insurance has been introduced; it combines both basic and major medical coverage.

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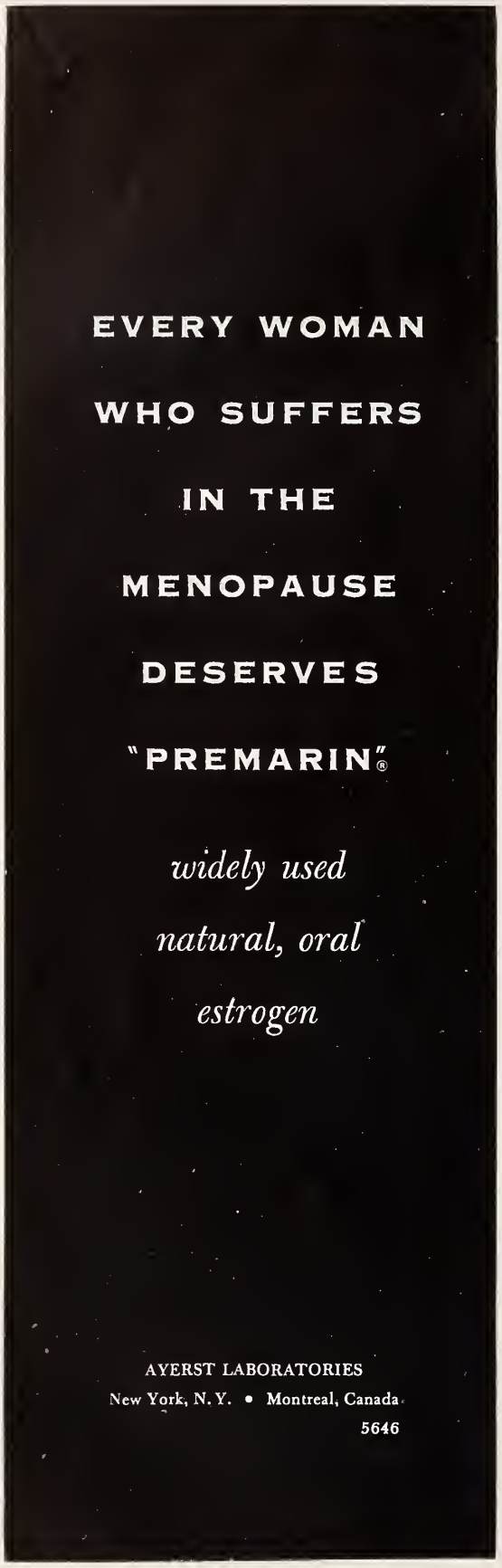
Bonica, J.J.; ond Backup, P.H. (Tacoma General Hospital, Washington): *Northwest Med.*, 54:22, Jan., 1955.

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Postherpetic neuralgia

The distribution of patients in the different age groups shows a progressive number and a lengthening of the duration of the postherpetic neuralgia as age increases. In other words, the prognosis of herpes zoster, as defined by the duration of associated neuralgia, seems to be related primarily to the age of the patient. All the patients in the different age groups received approximately the same type of treatment at the time of the herpes zoster. If treatment is good only in the younger age group, and is unable to control pain in the older age group, it is not very valuable. Treatment having a beneficial influence should affect all groups equally. In our series we have been unable to find any specific measures that affected markedly the natural course of the disease. *Jose M. de Moragas, M.D. and Robert R. Kierland, M.D. The Outcome of Patients with Herpes Zoster. Arch. Dermat. Feb.* 1957.

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Two things are as big as the man who possesses them—neither bigger nor smaller. One is a minute, the other a dollar.

—Channing Pollock

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An Analysis of an Internist's 1108 Consecutive Hospital Admissions

W. T. Couter, M.D., L. J. Hannapel, M.D., and C. L. York, M.D., Decatur

THE type of practice of an internist today varies widely depending upon his location and hospital affiliations. In a time of increasing specialization, his position in a medical community of what is becoming mainly specialists is in a state of flux. This is most apparent in smaller communities where an internist, practicing either alone or with a group, not only has a different status but encounters patients who differ from those seen in larger teaching centers or by metropolitan consultants.

We felt that an analysis of consecutive hospital admissions by internists practicing in such circumstances would illustrate our growing prominence in the role of family physicians and also would provide some significant and relatively unknown information concerning the incidence of disease in an unscreened population.

We practice as an informal group of six men consisting of three internists, a surgeon, a pediatrician, and an obstetrician — and the bulk of our practice is referred from patients.

Such a survey conducted by three men has more validity than a similar study conducted by one man, since the combination of data derived from the three practices tends to eliminate personal bias or error derived from one practice alone; all three series were in basic agreement on all points. During the greater part of this study, there were no interns in any Decatur hospital; consequently, any physician in a hospital at the time covered the emergency room. The majority of the obviously non-medical admissions were admitted through this means. To delete these admissions would militate against the accuracy of our presentation of a smaller community practice.

At the time the patient was discharged and the hospital chart completed, the basic card for this study was initiated. Decatur, a city of 70,000, has two general hospitals, and all Decatur physicians are members of both staffs. Hospital patient folders contain all hospital admissions. If time had clarified an initial impression, or if subsequent admission by another physician had changed our initial diagnosis we were able to correct our diagnosis on the card. This survey covers approximately eight man-years (WTC 1951-56), LJH (1954-56), CLY (1954-1956), and includes 854 different patients in the 1108 patient admissions. For all the patients, we have a two month follow-up; for approximately two-thirds, an eight month follow-up; and for one-half of the patients we have a year's follow-up.

Presented at the Southern Illinois Regional Meeting of the American College of Physicians, Springfield, Illinois, March 1956.

There was a preponderance of women in our hospital admissions. In the total series there were 655 women (59.1%) and 453 men (40.9%). This compares favorably with our previously described incidence of 65.5% women in our series of house calls.* The age breakdown of the patient admissions illustrated the importance of geriatric medicine as over one-third of the hospital admissions were 60 or over. By decades, the patient admissions were grouped as follows: Age to 9 years: 10 admissions (0.9%); 10-19: 44 (3.1%); 20-29: 128 (11.6%); 30-39: 164 (14.8%); 40-49: 182 (16.4%); 50-59: 176 (15.9%); 60-69: 181 (16.3%); and over 70: 223 (20.1%).

The next category illustrates a group of patients not always synonymous with the geriatric group but which, with it, contributes a problem of steadily growing incidence and importance. These are the hospital patients who are receiving some form of public assistance. In Illinois, this includes those receiving aid on local township relief as well as those who are receiving aid on a state level from Aid to Dependent Children, Aid to the Blind, Disability, Rehabilitation, Old Age Assistance, or similar programs. For purposes of this study, all such recipients were placed in the same group. This group, comprising 267 admissions (24.1%) of total admissions, was characterized by a high re-admission rate as one patient appeared 12 times in our statistics under various guises. There were 174 patients who made up these 267 admissions. Their average hospital stay was 10.9 days as compared to the private stay of 7.5 days. This, however, is not corrected for their difference in age and in disease.

We separated our admissions into two groups: those who for various reasons were admitted the same day were placed in the emergency group, and those who could be scheduled ahead were counted as routine admissions. In the emergency admissions were 378 admissions (34.2%) and in the routine admissions were 730 admissions (66.8%). The emergency group could be further divided into those admitted between 8 A.M. and 4 P.M.: 178 admissions (49.7%) and between 4 P.M. and midnight: 143 admissions (37.8%), and those admitted between midnight and 8 A.M.: 57 admissions (12.5%).

TABLE 1: DAYS OF HOSPITALIZATION

Days	Patient Admissions	Days	Patient Admissions
1	102	24	7
2	100	25	5
3	120	26	8
4	128	27	3
5	108	28	4
6	70	29	2
7	81	30	4
8	56	31	1
9	47	32	2
10	51	33	1
11	28	34	5
12	18	35	3
13	32	40	2
14	13	41	1
15	21	42	3
16	20	43	2
17	16	48	1
18	10	52	1
19	8	53	1
20	4	57	1
21	6	78	1
22	2	85	2
23	4	95	1

The length of the hospital stay was determined, and for more than half the patients this was 5 days or less. These hospital days are listed in Table One.

Such a large group of patient admissions contained many diagnostic and therapeutic problems, and in 395 (35.6%) we felt obliged to seek other opinions. There were a total of 412 consultations as a few of the patients were seen by more than one consultant. Surgical consultation was by far the most important, being obtained in 203 occasions. Other consultations were orthopedic-58; urological-45; neuro-psychiatric-32; gynecological-19; medical-16; neurological-12; otolargynogical-11; dermatologic-6; pediatric-5; obstetrical-3; and dental-2.

An internist is closely identified with cardiology and in a teaching center this may be an important factor in the bulk of his hospital admissions. However, in 782 (70.6%) patient admissions, an electrocardiogram was neither an integral nor a necessary part of the diagnostic workup; consequently, it was not ordered. In 326 (29.4%) patient admissions for whom an electrocardiogram was thought to be necessary and was ordered, a basic abnormality was present in 190 (58.3%). The use of X-rays

TABLE 2
58 DIFFERENT DIAGNOSTIC ENTITIES
OCCURRING 5 TIMES OR MORE

(Parentheses refer to corrected number of patients)			
Congestive Heart Failure			89 (47)
Arteriosclerotic, coronary heart disease	66	(33)	
Mitral stenosis	7	(5)	
Aortic stenosis	5	(2)	
Hypertensive	5	(5)	
Coarctation of the aorta	5	(1)	
Aortic Insufficiency	1	(1)	
Neuroses			79 (68)
Anxiety state	50	(49)	
Predominantly hyperventilation syndrome	8	(7)	
Mixed neuroses	14	(5)	
Reactive depression	7	(7)	
Irritable Bowel Syndrome			67 (62)
Peptic Ulcers			65 (65)
Uncomplicated duodenal ulcer	48	(48)	
Perforated duodenal ulcer	8	(8)	
Bleeding duodenal ulcer	1	(1)	
Uncomplicated gastric ulcer	8	(8)	
Cholecystitis, acute and chronic			50 (35)
Myocardial Disease			40 (39)
Myocardial infarction	32	(31)	
Coronary insufficiency without occlusion	8	(8)	
Cerebrovascular accidents of all types			39 (33)
Pneumonia of all types			34 (29)
Hypertension			32 (26)
Neoplasm			32 (23)
other than leukemia	26	(18)	
leukemia	6	(5)	
Low back strain			30 (30)
Bronchitis, acute and chronic			28 (25)
Diabetes			25 (23)
Diabetic acidosis	5	(5)	
Diabetes without impending coma	20	(18)	
Concussion			19 (18)
Rheumatoid Arthritis			15 (11)
Fracture			13 (12)
hip	5	(4)	
other	8	(8)	
Upper respiratory infection			12 (11)
Bronchial asthma			12 (6)
Rheumatic fever			11 (8)
Alcoholism			10 (10)
Laenec's cirrhosis			10 (7)
Contusion			10 (8)
Gastroenteritis (all kinds)			9 (7)
Addison's disease			8 (3)
Carbon monoxide poisoning			8 (8)
Psychosis of all kinds			8 (7)
Yo Yo Disease			8 (7)
Cellulitis			7 (7)
Hernia, inguinal			7 (7)
Pyelonephritis, acute and chronic			7 (7)
Prostatism			7 (7)
Relaxed pelvic floor			7 (6)
Ruptured intervertebral disk			7 (7)
Cystitis			6 (6)
Gout			6 (4)
Obstruction, secondary to adhesion			6 (2)
Osteoarthritis			6 (5)
Tonsillitis			6 (6)
Thrombophlebitis			6 (6)
Pelvic inflammatory disease			6 (6)
Renal stone			6 (6)
Sprains			5 (5)
Diverticulitis			5 (5)
			863 (720)

was more extensive and, excluding chest films which were a part of the admitting routine at both hospitals, some form of X-ray examination was used on 568 patients (51.2%). In 841 patient admissions, the type of X-ray was checked, and most frequent ones were: gastrointestinal and gallbladder series-110; spine-56; stomach alone-44; colon alone-43; skull-36; pyelograms (both intravenous and retrograde)-34; gallbladder alone-30; flat plate of the abdomen-27, and pelvis-18. X-ray of the gastro-intestinal tract obtained singly or in combination comprised 227.

An internist may see a bewildering array of psycho-somatic complaints; an attempt was made to determine the relative predominance of organic and functional disease in this series. We felt that the disease was predominanly organic in 870 patient admissions (78.5%), functional in 150 patient admissions (13.5%), and undecided in 88 patient admissions (8.0%).

An effort was made to evaluate the response to our therapeutic efforts. In the series of 1108 patient admissions, 972 (87.7%) were discharged as improved. There were 82 (7.4%) whose status was unchanged at the time of discharge. This group included persons who were admitted overnight for observation, patients who left against advice, therapeutic failures, and patients who were admitted p r i m a r i l y for diagnostic studies. In the main, this last group was admitted in good faith for a better preparation for a series of gastrointestinal X-rays than would have been possible in the home. This latter group also formed the basis for some interesting correspondence with insurance companies. Who pays for this variety of hospitalization is beyond the scope of this report. There were 44 such admissions (3.9%). We are unaware of

any similar statistical studies and we feel that such a group carries an importance far beyond its numbers, and that such studies are important to establish an actuarial basis for insurance premiums. In the entire group there were 54 deaths (4.9%).

There were 244 different diagnostic entities in 1,108 patient admissions, illustrating the wide sweep of internal medicine as practiced in our clinic. Of these—58 diagnostic entities occurred five times or more—and these 58 entities comprised 862 of the patient admissions. These entities appear in Table Two. Disease entities occurring less than five times were not of enough statistical validity to be included in this report. For the basis of this report, each patient admission was considered to be on the basis of one diagnostic entity. In the majority of cases, the primary diagnosis could be established with certainty but in a few, the decision was difficult and almost artificial. For instance, only three patients were involved in eight admissions for Addison's disease and one patient was admitted five times, but in each admission Addison's disease was considered to be the primary cause for the hospitalization. As might be expected, congestive heart failure was the most common cause for hospitalization; it was also characterized by the highest re-admission rate. We were surprised that the irritable bowel syndrome ranked third in this group as a cause for hospitalization; practically all in this group received a complete gastro-intestinal X-ray series, and in most, a proctoscopic examination in addition. Diabetes was the primary cause for hospitalization in only 25 admissions; it contributed to a far more important group numerically. Leukemia was a relatively common cause of hospitalization and an even more common cause of death. Outside the leukemias, there were only 26 neoplasms in this group of patient admissions; this is a disconcertingly small number in such a large series. However, through follow-up studies as already listed, we do not feel that we have missed a significant number or that enough of our initial impressions will have to be changed to make much of a statistical difference. The relatively high percentage of carbon monoxide poisoning is misleading since it arose when one of us was pressed into service via the emergency room to treat a busload of stricken baseball players. We were able to limit the diagnosis of yo-yo disease to 8 (0.7%).

CONCLUSION

The practice of an internist in a group clinic in a smaller community is discussed through the analysis of 1,108 hospital medical admissions of 854 patients as to sex, age, time of admissions, type of patient, diagnostic tests, response to therapy, and diagnosis.

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Not always Tbc.

In my opinion, in none of these diseases (Besnier-Boeck, chronic discoid lupus erythematosus, and granuloma annulare), has the tuberculous etiology been confirmed or ever made plausible. Indeed, feeble arguments can be adduced but these are not very convincing and, on top of that, often hold good only for too few cases, on the grounds of which general assumptions are made too easily. A mistake in clinical diagnostics or in laboratory experiments, the use of concepts that are too theoretical and often unjustifiable, may result in opinions that cannot stand criticism. As long as the tubercle bacillus has not been demonstrated as a cause, or the lack of success has not been made plausible in an acceptable way (as in the tuberculids), one should not derive evidence from statements that are too hypothetical. Danbolt's excellent chapter on sarcoidosis states the same opinion. *J. J. Zoon, M.D. Tuberculosis of the Skin. Arch. Dermat. Feb.* 1957.

Combined Hydrocortisone–Oxytetracycline Therapy in Ophthalmology

ALEX M. BERMAN, M.D., CHICAGO

HYDROCORTISONE, the chief product of the adrenal cortex, has been shown to suppress the inflammatory reaction in a wide range of disorders[1-9] but nowhere has its effect been more dramatic than in the treatment of ocular inflammations[10-11]. The fact that it exerts its effect directly at the tissue level increases its usefulness in ophthalmology, making possible local as well as systemic therapy. Hydrocortisone applied locally to the eye has been shown to penetrate the anterior chamber in therapeutic concentration[12] and local therapy has been employed successfully in the treatment of a variety of allergic and traumatic disorders of the conjunctiva, cornea, iris, and uveal tract[13-18].

In the practice of an active industrial clinic, the majority of ocular disorders encountered are acute superficial inflammations, many caused by foreign body penetration. In our experience local hydrocortisone therapy has alleviated pain and minimized residual corneal damage by suppressing the inflammatory reaction during the period of tissue repair.

The danger of secondary infection persists in such cases, however, and in an effort to reduce the incidence of infection it was determined to combine hydrocortisone with a broad-spectrum antibiotic suitable for topical use. This report presents our experience using an ophthalmic suspension containing hydrocortisone and oxytetracycline in the topical treatment of a variety of acute ocular inflammations.

MATERIALS AND METHODS

The patients observed in this study were drawn from the practice of an industrial clinic. The original group was a consecutive series of 50 patients with disorders likely to benefit from hydrocortisone therapy. Final results were obtained in 45 adult patients, 31 of whom were men. The conditions for which they were treated are listed in the table. In most cases the disorder was in an acute stage and had been present for two days or less.

Medication consisted of a suspension containing 1.5 per cent hydrocortisone acetate and 0.5 per cent oxytetracycline as the hydrochloride in a gel-like suspension*. Patients were instructed to instill two drops of the suspension into the eye every two or three hours. Other medications occasionally used included atropine, the sulfonamides, and boric acid compresses. The results of this therapy were evaluated in each patient as excellent, good, fair, or poor, taking into account the severity of the condition and the degree of relief of symptoms. Any undesirable effects of the treatment were considered separately.

RESULTS

The results of this trial are presented in the table according to diagnosis. It is seen that in 42 of the 45 cases (93 per cent) the results were judged excellent or good. In only one of our cases did the therapy fail to give at least partial benefit; this patient was allergic to the preparation, and his follicular conjunctivitis improved on withdrawing therapy.

Relief usually was obtained promptly, within 24 hours in most cases, and none of the patients experienced any return of symptoms when therapy was discontinued. The permanence of these results can be attributed to the fact that therapy was continued for at least several days after the condition was well controlled (the average duration of therapy in these patients was five days), and to the fact that the conditions being treated were largely self-limited.

Treatment was particularly successful among patients suffering from traumatic injury to the conjunctiva or cornea. Following various degrees of trauma to the external eye, and also following the removal of foreign bodies from the conjunctiva or cornea, this topical therapy induced rapid healing and diminished the time lost from work.

*The hydrocortisone-oxytetracycline suspension used in this study was supplied as Terra-Cortril Ophthalmic Suspension® by Dr. M. William Amster, Medical Department, Pfizer Laboratories, Brooklyn, New York.

Results of Hydrocortisone-Oxytetracycline Topical Therapy

Diagnosis	Number of Cases	Excellent	Good	Fair	Poor
Foreign body conjunctivitis	13	10	3		
Catarrhal conjunctivitis	9	8	1		
Corneal abrasion	5	4	1		
Purulent conjunctivitis	3	3			
Follicular conjunctivitis	3	1	1		1
Allergic conjunctivitis	2	2			
Corneal ulcer	2	2			
Blepharoconjunctivitis	2	1	1		
Acute iritis	2	1		1	
Actinic conjunctivitis	1	1			
Corneal opacity	1	1			
Contusion of eyeball	1	1			
Herpes zoster ophthalmicus	1			1	
Total	45	35	7	2	1
Per cent		77.8	15.6	4.4	2.2

The absence of residual cloudiness or opacity in these cases is notable and gives support to the idea that hydrocortisone therapy during wound healing maintains the clarity of the cornea.

One case deserves special mention. This patient stated that his vision had not been clear for over a year. A moderately thick corneal opacity in the pupillary area had resulted in a 40 per cent loss of vision as determined at the time of examination. Topical hydrocortisone-oxytetracycline therapy was started, and after less than two weeks the opacity had cleared and 20/20 vision was restored.

Only four instances were seen in which there was clinical evidence of bacterial infection on first examination. All responded promptly to the oxytetracycline component of the suspension used. Three of the infections were listed in the table as purulent conjunctivities; the other was a patient with allergic conjunctivitis whose lesions had become secondarily infected.

Throughout the study no development of secondary infection was observed in these inflammatory disorders, confirming the opinion that the addition of 0.5 per cent oxytetracycline to the suspension of hydrocortisone was an effective prophylactic measure during topical steroid therapy.

SUMMARY AND CONCLUSIONS

A series of 45 cases of superficial ocular inflammation, a majority of them induced by trauma, was treated topically with a combination of hydrocortisone and oxytetracycline (Terra-Cortril Ophthalmic Suspension). Results were excellent or good in 93 per cent, and therapeutic failure occurred in only one instance.

The therapy was highly effective in promoting rapid clearing of traumatic and allergic ocular inflammations, and in preventing infection and postraumatic corneal opacities.

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Recurrent Dislocation of the Ulnar Nerve

JOHN G. RAFFENSPERGER, M.D., CHICAGO

ONLY three cases of recurrent dislocation of the ulnar nerve have been reported in the American literature since 1908. This common lesion, though usually asymptomatic, can cause pain and paresthesias in hand and arm. It is easily diagnosed by having the patient flex his forearm against resistance, while the examiner palpates the medial side of the elbow. The nerve will be felt to slip from its groove over the medial epicondyle.

In 1851, Blattman, a Swiss surgeon, diagnosed the condition for the first time. The first American to report on ulnar nerve dislocation was Lutz who described a case in the St. Louis Medical and Surgical Journal.[1] Following F. Cobb's[2] reports of two cases and reviews of the literature in 1903 and 1908, there have been only three reports in the American literature.[1] Black and Arkin[3,4] each reported on individual cases which they treated surgically. Berman and Sutro[5] included in their report one case treated surgically and a discussion of the causes of ulnar dislocation. The foreign literature is replete with good papers on ulnar nerve dislocation. In 1918 Dubs[6] found 70 cases in the world's literature and added three of his own. Since then, 34 cases of ulnar dislocation with symptoms of ulnar neuritis severe enough to require treatment have been reported, making the total of 107 cases.

In order to determine the relative frequency of ulnar nerve dislocation to all causes of ulnar neuritis at the elbow, a series of cases of ulnar neuritis requiring anterior ulnar nerve transplantation were compiled from the papers of Platt, Nigst, McGowan and Richards[7,8,9,10]. Of these 156 cases of ulnar neuritis, 21 (13.5%) were caused by ulnar dislocation. All causes are compiled in Table 1.

TABLE 1
CAUSES OF ULNAR NEURITIS AT THE ELBOW JOINT

Previous fracture about the elbow joint	75
Osteoarthritis	28
Dislocation of the ulnar nerve	21
Congenital anomalies	4
Post-traumatic adhesions	6
Occupational pressure	7
Ganglion	3
Posterior dislocation of the elbow	1
Sepsis	1
Unknown	14

I am reporting on four cases of ulnar nerve dislocation found in patients presenting at sick call on one United States Navy ship having a complement of 1900 men.

Case 1: R.B. This right-handed 25 year old officer was first seen in November, 1954. He stated that five months previously, while his duties as a meteorologist required constant work at a drawing board, with arms flexed, he commenced having pain in his right elbow associated with numbness and tingling in the fourth and fifth fingers of his right hand. About a week later he noted similar but milder symptoms in his left extremity. Physical examination revealed diminished pain sensation along the ulnar border of his hand, weakness of

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his right grip, and guarding about the elbows. When his arm was moved from extension into full flexion, a firm cord could be felt to snap vigorously over the medial epicondyle. His left arm showed similar findings. Tests for the scalenus anticus syndrome were negative and X-rays of the cervical spine were normal. A neurosurgical consultant confirmed the diagnosis of ulnar neuritis but did not feel that enough nerve damage was present to warrant an anterior ulnar nerve transplant, despite the severity of the symptoms. The patient was observed for eight months and during this time he had constant paresthesias and occasional bouts of pain precipitated by exercise or trauma. He was advised to limit the use of his arm and occasionally an extension splint was necessary to relieve pain. At the most recent communication with him, he had been discharged from the service and was planning to seek treatment at a Veterans Hospital.

Case 2: A.T. This right-handed storekeeper was seen in January of 1955. For the previous six weeks he had felt a "burning type pain" along the ulnar side of his left hand and tingling in his fifth finger. He knew of no specific trauma but related the onset of his symptoms to carrying boxes from storerooms on board ship. Examination revealed slight diminution of pain sensation over the fourth and fifth fingers, weakness of grip, and a left ulnar nerve that dislocated completely anterior to the medial epicondyle. His symptoms were mild and no treatment was carried out in this case. After three months he had only occasional paresthesias but no pain.

Case 3: D.S. This 30 year old machinist's mate did not commence to have pain in his elbow until he was transferred from a sedentary master at arms job to one of pipefitting. He used his left arm and hand for all work and everything but writing. He was first seen in February of 1955, complaining of pain in his left elbow which had been present several weeks; he did not remember any specific injury. Physical examination and X-rays of the elbow at that time were not thought to be revealing and the only treatment offered was hot compresses. When seen again several weeks later he volunteered the information that the fourth and fifth fingers of his left hand kept "going to sleep" and that he had an unpleasant tingling in his hand. At that time he also noticed his left hand had become weaker than before. It was then found that the ulnar nerve would slip forward of the epicondyle on his left side. Examination revealed hypalgesia along the hypothenar eminence and over the fifth digit. On a dynamometer the left grip was measured at 120 pounds and the right at 170 pounds; this was considered significant because he used his left hand for most activities. An electromyelogram demonstrated definite fibrillation of denervation of the flexor carpi ulnaris and questionably of the abductor digiti quinti. The recommendation was made that this patient use his arm as little as possible and that continued observation would be necessary before considering an ulnar nerve transplant. Arrangements were made to limit his work and he had very little trouble as long as he did not forcibly flex his arm.

Case 4: B.T. This 23 year old sailor was first seen in March of 1955. He had injured his left elbow while playing ball a little over a month previously. Because of continued pain and swelling over the olecranon he reported to sick bay as soon as he arrived on ship. Examination revealed tenderness and swelling over the olecranon bursa and bilateral dislocating ulnar nerves. Both nerves dislocated with considerable force. The patient stated that he had always had snapping elbows but thought that it was normal. The only symptoms which could be related to his ulnar nerve were elbow pain and tingling in his right arm and hand after pitching several innings of ball. Local heat cleared his olecranon bursitis and nothing was done about the ulnar nerve dislocation.

DISCUSSION

Normally the two heads of the flexor carpis ulnaris muscle are united by transverse intercolumnar bands; these fibers with reinforcements from a band of fascia representing the epitrocleo-anconeus muscle serves to secure the ulnar nerve in its groove. The combination of poorly developed medial epicondyles and weak or absent transverse fibers usually is found along with dislocation of the ulnar nerve. Repaci and Santini[11], at the University of Genova, found in cadaver experiments that even when all the fibers securing the nerve are severed dislocation does not take place unless the nerve is impinged upon by the triceps muscle. Regardless of the causes of the dislocation, neuritis is seldom produced unless the nerve is further insulted by direct local trauma or the repeated minor insults of recurrent dislocations in people who must flex their arms frequently or forcibly.

At operation thickening usually is noted in the nerve sheath. Schildt[12] reviewed a series of 1816 people reported by various authors, 12 percent of whom had hypermobile ulnar nerves and all were symptomless. When ulnar neuritis does occur, pain is the dominant subjective complaint. It involves the elbow and the course of the nerve, varies in intensity, and is aggravated by activities involving forcible flexion of the arm. Two of my patients occasionally complained of pain in shoulder and neck. Paresthesias are common. Objectively, the nerve is sensitive at the elbow; sensory changes may be found in the ulnar area along with weakness of the hand. Of the 30 cases reported since 1918, only one has had marked atrophy of the interossei; the case was misdiagnosed as progressive muscular dystrophy.

Two others reported slight muscular atrophy but in the rest the lesion had not progressed to functional impairment. Patients with minimal symptoms will need no treatment; others may have to have their work limited to prevent symptoms from worsening. In my military situation it was easy to secure limited duty for a man if necessary. If the patient does have severe symptoms and cannot limit the use of his arms, operative treatment is indicated Anterior ulnar nerve transplantation gives excellent results provided the nerve damage has not been allowed to progress too far. I feel that my first case would have benefited from such an operation.

Summary: Recurrent dislocation of the ulnar nerve at the elbow has received scant attention in the American literature, but seems common enough to be included in the differential diagnosis of pain in the elbow, hand, or arm. The diagnosis is easily made by physical examination of the medial side of the elbow. If the patient can restrict the use of his arm without inconvenience, conservative treatment may be successful; if not, an anterior ulnar nerve transplantation is indicated.

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The other side

The addition of corn oil or any other oil to the American diet, without reducing the ordinary fats in that diet, can have little effect on the serum cholesterol level unless very large amounts are used, and this would mean an impossibly high caloric intake. There is no reason to believe that the addition of corn oil, sunflower seed oil, safflower seed oil, or fish oils to our diets, without other diet changes, could prevent or control coronary heart disease. Lastly, it should be realized that we are far from knowing all the answers. We need a great deal more research. But I doubt if the day will come soon when we can load our blood with fat without affecting cholesterol and blood coagueability. I see no prospect of preventing coronary heart disease merely by taking pills or capsules or periodic swallows of corn oil. *Ancel Keys, Ph.D. Calories and Cholesterol. Geriatrics, May* 1957.

Plazma Enzymes

Hyman J. Zimmerman, M.D., Chief Medical Service, West Side Veterans Administration Hospital

Doctor Samter: It gives me great pleasure to introduce one of the members of our own faculty, Dr. Hyman J. Zimmerman, Chief of the Medical Service at the West Side Veterans Administration Hospital, who will talk to us about recent advances in a relatively new area of clinical medicine, the area of blood enzymes which has received a great deal of attention in recent years.

Doctor Zimmerman: With your permission, I shall alter the title of today's talk to "Plasma Enzymes" since the enzyme systems within the formed elements of the blood present a separate topic. For orientation, let us first turn to Table 1 which illustrates a general classification of plasma enzymes.

Table 1

I. Proteolytic enzymes
  A. Plasmin
  B. Peptidases
II. Carbohydrases
  A. Amylase
  B. Glucuronidase
  C. Glycolytic enzymes
    1. Phosphohexosisomerase
    2. Aldolase
    3. Lactic Dehydrogenase
  D. Krebs Cycle enzymes
    1. Malic dehydrogenase
    2. Isocitrate dehydrogenase
III. Esterases
  A. Cholesterol
  B. Choline
  C. Aliphatic
  D. Phosphatases
  E. Desoxyribonuclease
IV. Glutamic oxaloacetic transmaminase
  Glutamic pyruvic transaminase

Peptidases of the serum have recently been studied in health and various disease states. Tripeptidases have been found elevated in such widely different clinical states as lymphatic leukemia, fever, barbiturate intoxication, acute rheumatic fever and hemolytic anemia. Dipeptidases were recently found to be elevated or depressed in hepatic disease depending on the particular type of dipeptidase being studied.

Carbohydrases constitute a fairly large group of enzymes. You all know that the serum *amylase* may be elevated in acute pancreatitis, intestinal perforation, or by morphine. I should like only to remind you that the amylase level may be depressed in hepatic disease. The *glycolytic enzymes* are increased in the serum of patients with carcinoma of either breast or prostate and are felt to reflect size of the tumor mass (and consequently both growth and response to therapy). *Lactic* dehydrogenase was originally reported to be increased in pregnancy and in tumor patients. We and others have found it elevated in many other disease states. This enzyme is one of the two I shall discuss in some detail later. *Aldolase* may be increased in many diseases other than tumor such as pancreatitis, infectious mononucleosis, delirium tremens, hepatitis, pneumonia, leukemia, and myocardial infarction. *Isomerase,* which is involved in change from glucose-6-phosphate to fructose-6-phosphate, is elevated only with liver metastases. *Malic dehydrogenase*

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has been reported to be elevated in patients with myocardial infraction.

Cholinesterase appears to reflect the albumin synthesis by the liver. With the single exception of nephrotic syndrome where it is found to be elevated, the cholinesterase level is low when serum albumin is depressed. Plasma levels of *desoxyribanuclease* have not yet been reported in disease states, to our knowledge.

At the West Side Veterans Administration Hospital, we have been interested primarily in two enzymes: latic dehydrogenase (LDH) and glutamic oxaloacetic transaminase (GOT). LDH is the enzyme which catalyzes the reaction to Lactate + PDN → Pyruvate + DPNH². The normal serum level we find to be 90-270 mmols% with a mean of 180. We have found that is is always elevated in patients with carcinoma which is disseminated whether or not the liver is involved. About half of our patients with lymphoma have an elevated LDH level as do most patients with granulocytic leukemia. Patients with lymphatic leukemia usually do not have an elevated serum level of this enzyme. Patients with myocardial infarction usually show an elevation from the first day until the tenth to fourtheenth day. We find it elevated in our patients with pernicious anemia and sickle cell anemia, but not in those due to blood loss or aplastic marrow. In viral hepatitis, LDH is increased only slightly in the first few days of illness. It is increased in cirrhosis only in the presence of jaundice. We have been somewhat confused by finding LDH elevated invariably in azotemia regardless of its etiology. The possibility that the enzyme is normally excreted in the urine has been considered, but we have not been able to demonstrate this in preliminary studies. The results of ureteral ligation in animals on the serum levels of LDH are under study.

Our hypothesis is that LDH is increased by regeneration or rapid proliferation of cells, by release from destroyed cells, or by anoxia.

Glutamic oxaloacetic transaminase is the enzyme which catalyzes the reaction Ketoglutarate + Aspartate → Glutamate + Oxaloacetate. In myocardial infarction, it is invariably elevated in the first 24-48 hours. Its rise is of shorter duration, but much greater magnitude than LDH, The normal level is 5-40. In patients with proven myocardial infarction, we have found GOT elevated in 32 of 34, LDH in 41 of 44, while both were elevated in 28 of 32. The LDH and GOT were each normal in only 2 patients.

In carcinoma, GOT is elevated only in presence of liver metastases unless the patient has co-existing viral hepatitis or myocardial infarction. In lymphomas, too, we found GOT elevated only in Hodgkin's disease with liver involvement. We found fewer patients with anemia have elevated GOT than LDH. GOT is elevated in infectious mononucleosis only in presence of jaundice.

It appears that tumor metabolism elevates aldolase and LDH. Tumor necrosis of liver cells elevates GOT. Hepatic disease causes elevation of many enzymes including GOT, GTP, peptidase, LDH, aldolase, and alkaline phosphatase.

While this is only a brief review of our experiences with plasma enzymes, it is undoubtedly evident to all of you that this is a young field with much yet to be learned.

Doctor Samter: I'm exhausted from this romp through strange country. Are there any questions?

Dr. Walter S. Wood, Instructor in Medicine: Have you determined enzyme levels in muscle diseases such as trichinosis, muscular dystrophies, or dermatomyositis?

Doctor Zimmerman: We have done little work along this line, but the Mayo Clinic reports elevated levels of GOT in patients with muscle necrosis, but normal levels with atrophy.

Doctor Adolph: LDH is increased in carcinoma even without metastases. Does this suggest differences in metabolism between LDH & GOT?

Doctor Zimmerman: As a matter of fact, we first knew of a difference in metabolism and then applied this difference to clinical studies. Anaerobic glycolysis is increased in tumor, and necrosis within it may release the enzyme.

Doctor Louis C. Johnston, Clinical instructor in Medicine: Do you find any correlation between enzyme levels and oxygen utilization by the tissues?

Doctor Zimmerman: Not specifically. Al-

dolase has been reported to be elevated in four of five patients with myxedema, but do not know why.

Doctor Frensters Does the initial GOT level in myocardial infarction help in prognosis?

Doctor Zimmerman: There is no correlation in our cases.

Doctor Ronald E. Fox, Instructor in Medicine: Does the enzyme level increase before there are EGG changes?

Doctor Zimmerman: It may.

Doctor Robert M. Kark, Professor of Medicine: Do you believe that these enzyme determinations improve your clinical acumen in diagnosis?

Doctor Zimmerman: No, rather they help us to understand disease better.

Doctor George A. Saxton, Jr., Associate Professor of Preventive Medicine: Have cerebrospinal fluid levels been reported?

Doctor Zimmerman: The levels are lower than serum—in the range of 1-3 for GOT. One patient with meningococcal meningitis showed a level of 32.

Doctor Harry A. Bliss, Assistant Professor of Medicine: Have you studied changes in normal subjects after exercise or starvation?

Doctor Zimmerman: No, but this poses an interesting problem which should be investigated.

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New test for early diabetes

Intravenously administered sodium tolbutamide produces a prompt and rapid fall in blood sugar in normal subjects, whereas mild diabetics exhibit a gradual decline. The purpose of this study was to determine if these differences might serve as a diagnostic test for early diabetes. One gram of sodium tolbutamide was administered intravenously over a two-minute period, and the blood sugar concentrations were measured at 20 minute intervals for the ensuing two hours. The responses of 15 mild diabetics with fasting blood sugars ranging from 72 to 187 mg. % were compared with those of 17 nondiabetics. The standard three day preparatory diet preceded each test. Striking difference in response was observed. Without exception, the blood sugar levels of the diabetics declined slowly over two hours or more, while the normals exhibited precipitous falls in blood sugar within the first hour, followed by a return toward normal. Complete separation of the two groups was noted at 40 minutes after the injection; at that time the mean fall in blood sugar among the diabetics was 10.5 per cent of the fasting level (S.D. 6.3), while the decline among the normal subjects averaged 45 per cent of the fasting level (S.D. 11.7). Although justifiable on empirical grounds alone, the rationale of the test is based on evidence, not yet incontrovertible, that sulfonylurea-induced hypoglycemia results from enhanced insulin release. The use of a nonglucose "betacytotropin" to test beta-cell function has theoretical advantages over both oral and intravenous glucose disappearance unobscured by the caprices of gastrointestinal absorption of glucose which beset the oral glucose tolerance test and free of mass action effects induced by rapid intravenous administration of glucose. *Robert H. Unger, M.D. and Leonard L. Madison, M.D. A New Diagnostic Test for Early Diabetes Mellitus. Clin. Res. Proc. April* 1957.

A New Method of Pelvic Fixation

William Johnson, M.D., Galesburg

THE speed age in which we now live has given rise to a number of new situations encountered only infrequently in past decades. Comminuted pelvic fractures in which half the pelvis is avulsed from the other half and from the sacrum is a phenomenon of increasing incidence resulting from this speed age.

Our automobiles today resemble eggs which on impact spew their contents in all directions. Often, as a result of a crash, the car will throw its occupants from its confines and then proceed to roll. Should one of the occupants be caught lying on his side as the car rolls over him, he will be caught in the jaws of this giant nutcracker.

The four cases upon which this report is based occurred in this manner. All the injuries to the pelvis followed a rather definite pattern. Posteriorly the sacroiliac joint was avulsed, fracturing a portion of the sacrum or the ileum in that area. Anteriorly, both rami of the ischium and pubes were fractured on either one or both sides, so that the entire coxal bone on the one side was separated from its attachment to the opposite side. (Figure 1)

Dr. J. Grant Bonnin, of the Central Middlesex Hospital in England, said in approaching the subject from the mechanical aspects, that there are three zones of weakness in the pelvis: the anterior zone including the pubic symphysis; the central zone with a weak acetabular floor; and the posterior zone comprised of the sacroiliac joint, the ala of the ileum, and the lateral mass of the sacrum.

In this discussion, no reference will be made to the numerous injuries to any pelvic structures, other than the bony pelvis.

Having treated several fractures of this character by conventional methods with unsatisfactory results, I concluded that a method of grasping the bony pelvis in some rigid, positive manner was necessary to relocate these fragments in their anatomical position. An idea was worked out on a pelvic skeleton (Figure 2). I discovered that the ileum would receive and hold pins up to 5/32″ in size, when these pins were directed downward and medially. By placing a cluster of three pins in each iliac crest and attaching them by means of clamps and bars to other pins placed in the public ramus or sub-

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Figure 1

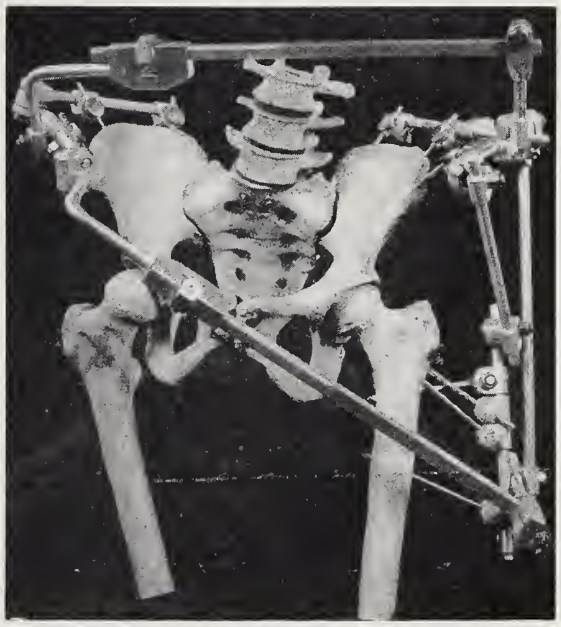


Figure 2

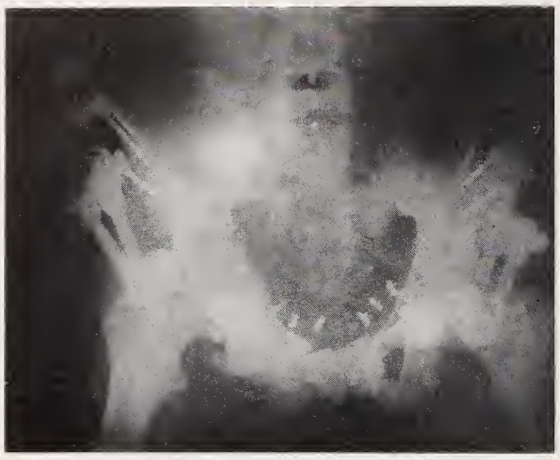


Figure 3

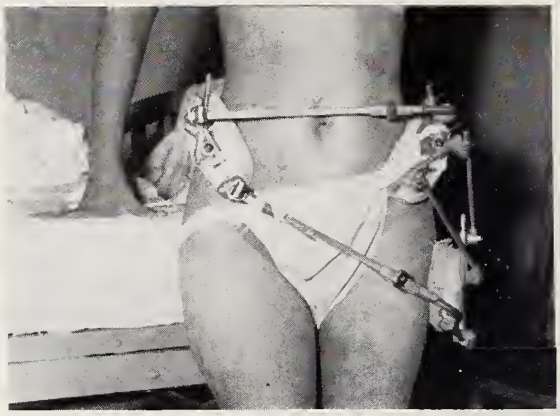


Figure 4

trochanteric areas, it was evident that these fragments could be controlled from outside the body. An old device, the turnbuckle, was then attached to the fixation units described above to enable us to move the fragments into their correct position. The pins had to be directed in the proper plane through the soft tissues so that there was no pile-up and resultant necrosis of these tissues on one side of the pin.

The pins were so placed that when connected with each other by means of the clamps and bars, they formed a triangle. This prevented pin travel. Movement of the pins in the soft tissue was eliminated by firm gauze or felt around the pins.

Subtrochanteric fixation on the well side and the resultant locking of the hip joint provided a low anchor point for an oblique bar or turnbuckle, allowing rotation of the ileum in the transverse plane (Figure 3).

Open reduction of fragments that have strayed too far away may sometimes be necessary. A modified fanenstel type of incision, super-pubic incision permits exploring the bladder and bringing back home the strayed fragments. Rigid fixation lessens shock. Final reduction may be delayed for a few days, but remember that the membranous bone heals very rapidly.

One young woman shortly after fixation was flown in an airplane a distance of some 300 miles. Following recovery she had a full term pregnancy with normal spontaneous delivery through the vagina (Figure 4).

SUMMARY

A new type of severe pelvic fracture has appeared as a result of the speed age — the nutcracker fracture. A new type of fixation has been applied to restore anatomical relationships of through and through pelvic fracture.

Some Observations on Tests for Tetany

Austin J. McSweeny, M.D., Danville

The syndrome of tetany has intrigued clinicians since 1830, when Steinheim[1] described what he believed to be a curious form of acute articular rheumatism. Twenty-two years later, Corvisart[2] conferred the designation of tetany, the name by which the condition is known today. This syndrome is caused by disturbances in calcium and acid-base balance and is manifested by characteristic features of increased neuromuscular irritability. The proper evaluation of a patient in whom there exists a question of tetany entails complex procedures such as blood chemistry determinations and, in some cases, testing of neuromuscular responses to galvanic stimulation. However, the clinician will almost invariably include in his study certain signs, which can be elicited by a simple means in the course of physical examination. The Chvostek sign[3] and Trousseau's phenomenon[4] are foremost among these. Although Lust's phenomenon or the peroneal sign also is commonly known as a test for tetany,[5-7] it is used less frequently than the other two. The precise significance of a positive response to one or more of these clinical tests needs clarification, and references to the frequency of their occurrence in normal individuals are often vague. This paper is a report of an evaluation of tests for latent tetany as studied in 500 patients.

METHOD OF STUDY

Five hundred consecutive medical out-patients seen from August 1955 to July 1956 were tested for the presence of the Chvostek sign, Trousseau's phenomenon, and the peroneal sign. The patients ranged in age from 15 to 85 years; 406 were Caucasian and 94 were Negroid; 218 were men and 282 were women. In none was there any reason to suspect tetany.

The facial phenomenon was induced by digital percussion anterior to the ear and inferior to the zygomatic process. A positive response consisted of contraction of the facial musculature, and in this series responses were graded according to the height to which muscular contraction extended: 1+ upper lip, 2+ musculature about the ala nasi, 3+ musculature about the eye, and 4+ responses including the facial muscles of the forehead. In the latter 190 patients examined, notation was made as to whether the response was induced by percussion of the preauricular or subzygomatic area. However, both maneuvers were carried out in all 500 patients.

Trousseau's phenomenon may be elicited by sustained compression of the subject's upper arm. In this series compression was accomplished by the application of a pneumatic cuff to the middle third of the arm. The cuff was inflated until its pressure exceeded the patient's brachial arterial pressure, and it was left inflated for a period of three minutes before the test was considered negative. The technique as outlined is believed to be the procedure most commonly employed in this country although variations of this method may be used. Only objective changes were considered significant in judging the positive response. The changes present in all those with positive tests included adduction of the thumb, flexion of the metacarpo-phalangeal joints, extension of the distal interphalangeal joints, and stiffness of the fingers as determined by the examiner. Paresthesias and suggestive hand postures without associated digital stiffness were not accepted as evidence of a positive Trousseau phenomenon.

The peroneal sign, or Lust's phenomenon, was induced by hammer percussion of the common peroneal nerve on the lateral surface of the neck of the fibula. A positive response may include dorsiflexion, abduction, and eversion of the foot. Positive responses were graded from 1+ to 3+ depending upon their general magnitude.

RESULTS

The accumulated data were analyzed accord-

From the Danville Polyclinic

TABLE 1
RESULTS OF TESTING 500 PATIENTS FOR SIGNS OF TETANY

Category	Number Tested	Chvostek Sign Number Positive	Chvostek Sign Per Cent Positive	Peroneal Sign Number Positive	Peroneal Sign Per Cent Positive
Total	500	129	25.8	150	30.0
Male	218	43	19.7	87	39.9
Female	282	86	30.4	63	22.3
Caucasian	406	94	23.2	115	28.3
Negroid	94	35	37.2	35	37.2
Age Group					
15-20 years	47	21	44.6	8	17.0
21-40 years	240	83	34.6	80	33.3
41-60 years	135	43	31.9	43	31.9
61-85 years	78	3	3.9	16	20.9

ing to sex. race, and age. The findings are presented in Table 1.

The finding of a positive Chvostek sign in 25.8% of all patients tested is not out of keeping with the experience of earlier investigators. It approximates Pavel's and Cornateanu's findings in 1928.[8] The preauricular maneuver elicited a positive response in 7.4% of the patients tested. This corresponds exactly with the experience of Pavel and Cornateanu. All patients who exhibited positive facial phenomena on percussion of the area in front of the ear also exhibited this sign with subzygomatic percussion. Asymmetry of response was not uncommon, but a unilateral Chvostek's sign was observed in only one patient. Of these 129 patients, 7.8% had a 2+ Chvostek. Eight patients, or 6.2%, showed a 3+ Chvostek. Only one patient in the entire group (0.8%) had a 4+ Chvostek sign.

Four patients, or 0.8%, of the 500 tested exhibited a positive Trousseau phenomenon. Follow-up examinations were carried out on our patients, and in three the Trousseau phenomenon could not be reproduced. In the fourth, the Trousseau phenomenon occurred again only to be found absent at a later date. Similarly variable results on follow-up study in the case of Chvostek's sign have been noted before.[8] Literature references to the physiologic occurrence of the Trousseau phenomenon differ considerably. According to Wechsler,[9] this sign occurs only in tetany. In 1946 Kirstein and Kugelberg[10] encountered the Trousseau phenomenon twice in a series of 48 normal female subjects, and they reported an incidence of 4.2%.

Thirty per cent of our patients exhibited a positive peroneal sign. No earlier comparable studies have been found in a review of the literature. It appears that this sign has had minimal study and evaluation as a test for tetany. Of the 150 patients in our series who exhibited a positive Lust's phenomenon, 63, or 42.0% were graded as 1+; 68, or 45.3%, had a 2+ peroneal sign; and 14, or 9.3%, had a 3+ response.

DISCUSSION

Neuromuscular excitability varies with the ratio of the serum sodium and potassium to the serum calcium, magnesium, and hydrogen (or hydronium) ion concentration. Tetany may be precipitated by any one of the many well known causes of hypocalcemia. Since only the ionizable form of calcium affects neuromuscular excitability, changes in the proportion of ionizable to nonionizable calcium may cause tetany even when the total serum calcium is normal. Such is the case in citrate and oxalate tetany.

Whereas an increase in the hydrogen (or hydronium) ion concentration tends to inhibit tetanic signs, alkalosis — regardless of its etiology — is a well known cause of tetany. Less well established as a clinical syndrome is tetany due to hypomagnesemia. Although Miller[11] reported what appeared to be a representative case in 1944, subsequent studies have failed to confirm the role of magnesium deficiency as a cause of tetany in the human. Magnesium deficiency is manifested by gross muscle tremor, choreiform movements, and in some instances, by convulsions rather than by the syndrome which is produced by hypocalcemia or alkalosis.[12] Although disturbances in potassium balance are not primary causes of tetany, they may function as contributory factors. If the serum potas-

sium level is abnormally low, tetany may not occur even though hypocalcemia exists. In such a case correction of the hypocalcemia may precipitate tetany.[13]

The pathophysiology of Trousseau's phenomenon has long been a matter of dispute. In 1907 von Frankl-Hochwart[14] demonstrated that in the parathyroidectomised dog, pressure on an exposed nerve caused muscle spasm. However, direct blood vessel pressure was without effect. More recently Harvey and Lilienthal[15] elicited spasm in the hand of a patient with hypocalcemic tetany, although the motor fibers had been blocked distal to the level of the pneumatic cuff. This experiment and others lend considerable support to the theory that ischemia rather than nerve pressure is responsible for the increase in nerve excitability seen in Trousseau's phenomenon. Nevertheless, there are current proponents of the nerve pressure theory. There is little argument about the etiology of Chvostek's sign and Lust's phenomenon also is generally accepted as a manifestation of mechanically induced nerve stimulation.

It is apparent that none of the signs tested in the present series can be considered as pathognomonic of tetany. However, Trousseau's phenomenon was present in only four patients, or 0.8%. This percentage is low as compared to the findings of Kirstein and Kugelberg[10] (4.2%) and it increases the clinical significance of a positive test. Several factors may explain this discrepancy. The latter investigators placed the pneumatic cuff as far proximal as possible on the subject's arms. This is said to increase the sensitivity of the test. Arm compression was applied for five minutes rather than three minutes to all patients. Since the number of patients examined was small (48), the statistical error may be quite significant. Only female subjects were tested, and it is possible that other variables such as race and age were of importance.

In our series no parallelism was found between the occurrence of the Chvostek sign and the peroneal phenomenon. Only 45 patients, or 9.0%, had both of these signs simultaneously. A purely chance relationship would be expected to produce an incidence in the neighborhood of 7.7%.

The peroneal sign is particularly difficult to evaluate. Repeated examination of the same subject at the same sitting may produce surprisingly variable results. The apparent capricious nature of the test cannot be explained on the basis of anatomic variation in the position of the common peroneal nerve. The latter's relations to the fibula are reported to be remarkably constant.[16] The greater frequency of the peroneal sign in the male (39.9%) as compared to the female (22.3%) may be related to the cushioning effect of the subcutaneous adipose tissue in the latter group. Although the peroneal sign is commonly known as a test for tetany, a review of the medical literature has revealed little in the way of clinical studies of this sign in tetany or in normal individuals.

SUMMARY AND CONCLUSION

1. Five hundred consecutive adult subjects seen between August 1955 and July 1956 were tested for signs of tetany.

2. Although no sign tested was found to be pathognomonic of tetany, Trousseau's phenomenon approached that status, occurring only in 0.8%. Tests for tetany should have greatest significance when the individual's normal reaction is known. Thus, the presence of a positive Chvostek's sign in an individual who is known to have had a negative test prior to thyroidectomy has considerable significance. However, even under such ideal circumstances results cannot be regarded as absolute, because the phenomenon may vary from time to time in the same normal individual.

3. The overall incidence of the Chvostek and peroneal signs was 25.8% and 30.2% respectively.

4. Age, race, and sex altered the incidence of the Chvostek and peroneal sign significantly. Young adults (age 15 to 20) showed the Chvostek sign in 44.6%, whereas the oldest group (age 61 to 85) had an incidence of only 3.9%.

5. The peroneal sign is of doubtful value. The examiner may have difficulty determining if a lack of response indicates a negative test or failure to effect an adequate stimulus to the common peroneal nerve. Reports of experience with the peroneal sign in tetany are insufficient to assess its true value when the syndrome exists.

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Procaine amide for the heart

Articles published during these 6 years suggest that procaine amide is an effective antiarrhythmic agent whose major uses appear at present to be as follows: 1. For the management of ventricular premature contractions whether due to intrinsic heart disease, digitalis toxicity, or unknown cause. 2. In the management of ventricular tachycardia, particularly when it is desired to use an intravenous agent. 3. For the treatment of nodal arrhythmias and recent atrial arrhythmias. 4. During the course of myocardial infarction as a prophylaxis against ventricular tachycardia and fibrillation, once ventricular premature contractions are observed. The authors do not recommend its use routinely as a prophylactic agent in surgery or cardiac catheterization, since the drug does not appear to exert much control over extrasystoles due to mechanical stimuli.

That this compound was found, suggests that other compounds with these pharmacologic properties exist, some perhaps even more potent and less toxic than procaine amide. Certainly, a further search is warranted. *Herbert J. Kayden, M.D., B. B. Brodie, Ph.D., J. Murray Steele, M.D., "Procaine Amide", Circulation, January* 1957.

Experiences with Metrazol Therapy in Senile Individuals

Leonard Sluzynski, M.D., Chicago

IN a home for the aged there is always the problem of caring for individuals who, while not ill, are inept, have a poor memory, often are unable to dress themselves or even to eat alone. Many cannot make their wants known and so unwittingly or otherwise soil their clothes and beds. Whether these deficiencies stem from senility, cerebral arteriosclerosis, mild senile psychoses, or a combination of such disorders is beside the point.

The numerous papers in the literature attesting the benefits derivable from oral pentamethylenetetrazol (Metrazol®) therapy motivated a trial of this analeptic on our group of old people.

The value of Metrazol in geriatric cases seems to lie in its ability to stimulate the whole central nervous system, but especially the medullary centers, thus improving respiration and also indirectly, the circulatory processes. Skeletal muscle action and nerve impulse transmission across the synapses likewise are reported to be enhanced. It is clear that a combination of these effects should be of distinct benefit in aged, asthenic, or depressed patients.

We are reporting here on 18 patients, average age 84 plus years, who received 2 teaspoonfuls of elixir of Metrazol, equivalent to 200 mg. of Metrazol, four times a day. This liquid form of medication was much preferred to the tablets.

Occasionally, due to intercurrent disabilities, the dosage was temporarily reduced to 4 cc. a day. Other medications in the form of vitamins, nicotinic acid, and hematinics were administered as indicated. In special cases, digitalis, insulin, hormones, diuretics, vasodilators, sedatives, or antirheumatics were given.

Our results were judged on a purely clinical basis by comparing the opinions of those who daily cared for these senile individuals with the opinions of the relatives and of such other persons as came into frequent contact with the patients. No particular efforts were made to assemble specific scientific data. No psychologic tests were done. Such tests as the Bellevue-Wechsler scale, Kent EGY, and Rorschach test are much too complicated for many of these old people as has been pointed out before.[3,5,6]

We needed no elaborate setup to recognize improvement if the patient had shown no significant mental change on previous medication and—directly following the Metrazol therapy—was more willing to get out of bed, and better able to care for himself so far as eating, dressing, and toilet habits were concerned, or showed improvement in mood and general behavior, orientation, interest in his environment and less antisocial behavior.

Of our 18 patients we considered 7 to be much improved, 6 moderately improved, 4 slightly better, and one unchanged. The "degree" of improvement was the deciding factor in placing a patient in one or the other of the above groups. Thus, a "much improved" patient — for instance, a bedridden patient who now voluntarily got up and took an interest in his surroundings —might still be mentally and physically worse than another only moderately improved patient who had much less disability from the start.

The following three cases may illustrate three such different degrees of improvement:

Case S. Z.; Male, 88 years old, was bedridden, weak, and unable to walk due to a "stroke" suffered in the spring of 1955. His blood pressure ranged from 150/90 to 174/100, according to the degree of his activity. He had a severe degree of generalized arteriosclerosis. He improved gradually and regained some motion in his paralytic side; however, his mind became hazy and he was out of touch with his environment. In the fall of 1955, he was put on Metrazol and since that time has improved to such an extent that he now goes down to the basement and does odd jobs and, in general, is able to take care of himself very well. He is less "crabby" and his appetite has improved. The blood pressure range is about the same as before the administration of Metrazol. In spite of the remarkable improvement, the patient still becomes slightly confused and talks rather queerly at times.

Case E. K.: Female, 82 years old, has hypertensive

blood pressure with a range of 190/90 to 220/110 during the past five years. The patient also presented an old obliterative arteriosclerosis of both lower extremities for which various medications had been prescribed without much relief. This caused us great concern. Aside from the severe pain in the legs, the woman had a poor appetite, was unhappy, and complained bitterly of dizziness. Metrazol elixir, 1 dram q.i.d., was started in March of 1956 and resulted in the greatest improvement she had yet experienced. There are now fewer complaints of pain in the lower extremities due, I believe, to the improvement, by the added Metrazol medication, of the circulation and blood oxygenation in the obliterative sclerosis of the legs. The blood pressure readings remain about as before but the vertigo is no longer so severe.

Case J. D.; Female, 79 years old, occasionally out of contact with her environment. She complained of various aches and pains and some difficulty in walking. Her main syndrome is one of general cerebral vascular disease with a blood pressure range of 168/80 to 200/80. The patient was put on Metrazol liquidum in May of 1955. She has improved somewhat, but occasionally is still out of contact with her surroundings. Our general impression is that she has been improved a little. The blood pressure since taking Metrazol shows somewhat lower values. It now ranges from 142/74 to 170/80.

While in some patients, improvement became evident in a week or 10 days, in others a month or more passed before a beneficial result of Metrazol administration could be unequivocally determined.

After maximum benefits had been attained, a maintenance dose of about half of the previously given therapeutic dose generally sufficed to sustain the patient at the previously reached improvement level. If medication was stopped, regression could be expected after a month or more.

Complications from Metrazol administration were completely absent. Blood pressure was not influenced significantly. In the asthenic patient it might be raised. In some cases of hypertension, lower values were found after Metrazol therapy than before treatment. In no case was hypertension made worse. This has also been seen by other therapists.[1,2] Appetite was frequently improved.[4]

SUMMARY

In a group of patients with a mean age of over 84 years, it is too much to expect that any form of therapy will bring back the status of younger years. However, in our small series of 18 cases the results with oral Metrazol therapy were very satisfactory since 7 of the 18 patients were much improved, 6 moderately so, 4 slightly, and only one showed no benefit from the treatment. Even moderate improvement on a ward for senile patients is of distinct value, will make nursing care easier, and free personnel for the care of the more helpless inmates. Indeed, the whole atmosphere of such a ward may be changed for the better.

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Leonard S. Sluzynski, M. D.

COOK COUNTY HOSPITAL CASE RECORDS



Intercurrent Acute Appendicitis in Surgical Patients With Other Abdominal Pathology

PETER BEACONSFIELD, M.D., AND HERMAN A. JACOBSON, M.D., CHICAGO

THE danger of failing to recognize acute appendicitis is never greater than when a patient is hospitalized in a surgical ward for the treatment of some other known abdominal pathology. The three patients presented below are cases in point, and we feel that they are worthwhile reporting.

Case 1. Mr. L. M., age 44 years, was admitted to the hospital for a gastric resection. He had a long history of duodenal ulcer, for which he had been treated medically on and off for the past six years. During the past six months he showed signs and symptoms of duodenal stenosis both clinically and radiologically.

While in the hospital being prepared for surgery he was symptom free. On the 4th day after admission he developed epigastric pain which radiated to the back. The pain was similar in nature and distribution to that experienced during previous exacerbations of his duodenal ulcer. On this occasion, however, antacids afforded him no relief and vomiting, which had often eased his discomfort in the past, did not do so when he brought up his stomach contents.

Three hours after commencement of the pain the patient was examined. There was tenderness in the epigastrium but no distention, rigidity or rebound tenderness were manifest. The rest of the abdomen revealed no abnormalities. A rectal examination was not done at this time.

The epigastric discomfort persisted but the pain slowly shifted to the right side; and five hours after the commencement of the attack it was located midway between the costal margin and iliac crest. The patient experienced some nausea without vomiting at this time. Finally, when he was examined ten hours after the pain had started there was definite tenderness in the right lower quadrant with guarding and rebound tenderness. A rectal examination now done for the first time revealed marked tenderness on the right. The W.B.C. was 11,000.

A diagnosis of acute appendicitis was made and confirmed at operation.

Case 2. Miss P.R., age 53 years, was admitted to the hospital as an emergency for the repair of a perforated duodenal ulcer. Her immediate postoperative course was uneventful. On the fifth postoperative day, however, the patient developed abdominal pain. This was initially mid-abdominal in character but, within four hours, it concentrated in the right lower quadrant. The patient had some nausea but no vomiting, and

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a normal bowel movement during the period of discomfort.

Physical examination revealed tenderness, some guarding, and rebound tenderness on the right side of the abdomen particularly in the right lower quadrant. Rectal and vaginal examinations were negative.

After this examination a diagnosis of acute appendicitis was made. No W.B.C. was done as it was felt that this would in no way alter the diagnosis.

At operation a retrocecal suppurative appendix was removed.

Case 3. Mrs. B. P., age 33 years, was admitted to the hospital with a 12 hour history of right upper quadrant pain which radiated to the back and towards the epigastrium. She vomited once, but had a normal bowel movement on the day of admission.

Physical examination revealed marked tenderness and guarding in the right upper quadrant without actual rigidity or rebound tenderness. Temperature was 101°. The patient stated that she had suffered a similar attack three years prior to present admission. While having no intolerance to fatty foods, the patient stated that she had experienced bilious vomiting and epigastric discomfort following ingestion of cabbage or spicy foods. Her W.B.C. was 15,000. A diagnosis of cholecystitis was made, and the patient was placed on antibiotics.

Twelve hours after admission the patient complained of increasing pain. Rigidity and rebound tenderness were now present, and bowel sounds were hypoactive. Temperature was 102°. Two hours after this last examination a cholecystectomy was performed. The gall bladder was acutely inflamed and full of stones. It also contained a considerable amount of purulent material.

The patient's immediate postoperative course was uneventful. Her fever returned to normal and she was ready to be discharged when, on the 8th postoperative day at 9 a.m., she complained of lower abdominal pain in both left and right lower quadrants. There was some nausea but no vomiting, and she had passed gas per rectum the same morning. The patient said she had just finished menstruating the previous night and added that she had been treated for "infected tubes" a year prior to present admission.

Physical examination revealed tenderness in the left and right lower quadrants. There was no distention but some guarding, and rebound tenderness was present bilaterally. Bowel sounds were normal. Pelvic examination revealed that both the cervix and adenexae were markedly tender. The patient was again placed on antibiotics, these having been discontinued on the 3rd postoperative day.

At 3 p.m., six hours after the initial examination, the patient was in acute distress. Pain was now severe and localized entirely in the right lower quadrant. There was also some rigidity. Temperature was 102°.

The diagnosis of acute appendicitis was made and, at operation, the patient was found to have an acute suppurative appendicitis.

Appendicitis is probably the commonest of all surgical complaints. It has been extensively written about and discussed for centuries, and it would seem that little can be added to our knowledge and experience of this condition. The three patients reported above further demonstrate the apparently infinite variety in the signs, symptoms and circumstances of acute appendicitis. They also tend to strengthen the opinion that, in any patient who develops abdominal discomfort or pain, the examining physician should always bear the possibility of appendicitis in mind.

EDITORIALS



Asiatic flu

The influenza epidemic in the far east is said to be headed for the Americas. In all probability, it will not reach us until the fall or winter. No proved case of this type of influenza has been reported here, although we have overheard laymen remark that they were ill recently with "the Asiatic flu that you read about."

With the approach of autumn we can expect to hear more and more comments along this line. The physician should be careful not to diagnose an isolated case Asiatic flu unless the diagnosis is substantiated.

The epidemic in the far east has been caused by a new strain of influenza A virus that is not controlled by the current influenza vaccine. Samples of the virus were sent to American manufacturers and a vaccine is being prepared for general distribution.

Oriental influenza is a mild disease even though a few deaths have been reported. The symptoms are those of the ordinary flu. Quarantine inspectors will advise travelers from the orient and Philippines to consult their private physicians if they develop a respiratory disease within ten days after arrival. Those who are ill on arrival will be reported to their local health officers.

Collaborating laboratories are being supplied with the antigens for indentification of the new strain. All state and local health officers will be informed about the testing system. Private physicians are asked to report suspicious cases. There is no specific treatment. The antibiotics prevent bacterial complications that have caused deaths in past epidemics.

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The church and medicine

"It is the mark of a good hospital that its patients should be cared for as persons and not as cases. Each human being is more than a mere simple physical entity. In every living individual there is a temporary association between an immortal spirit and an exquisitely balanced nervous system which controls the body. The aim of this hospital is the complete recovery of the patient so that he can go out fully restored, refreshed and reanimated, ready to face life without fear and anxiety. The form of courage most helpful to recovery is that based upon trust in God and the readiness to accept whatever may come and make the best of it. For this peaceful and fearless courage, the chaplain as well as the other members of the team can do much to help the patient toward this ideal fulfillment."

According to the Reverend T. C. Speers, every new patient arriving at the Royal Victoria Hospital in Bournemouth, England receives this statement signed by the matron, chaplain, and the medical and surgical staff.

There is no doubt that religion plays a role in healing and this is a good example of how the clergy and the physician work together. The priests were our predecessors in the practice of the healing, but we can be thankful that the church and hospital drifted apart. This proved

to be an advantage to the medical profession especially in those countries where the church came under the domination of the government.

James Anthony Froude, the 19th century English historian writing on the stifling effect of government of the Church of England, once said, "If medicine had been regulated 300 years ago by Act of Parliament, if there had been 39 articles of Physic (referring to 39 articles that formed the constitution of the Anglican or Episcopal Churches), and every licensed practitioner had been compelled under pains and penalties to compound his drugs by the prescriptions of Henry the VIII's physician, Dr. Butts, it is easy to conjecture what state of health the people of this country would be found."

The modern physician is aware of the need for religion in medicine and never hesitates to ask the clergy for spiritual assistance. According to the Reverend Speers, "We need each other. It is not a case of a doctor or a clergyman. The fact is we need the doctor and the clergyman. That strange, invisible, intangible quality, the spirit of man, his thoughts, his feelings, his emotions, his fears, his hopes, his unconscious motivations, impinge upon his body and to some measure at least condition it."

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Actions of A.M.A. House of Delegates at 106th Annual Meeting

Revision of the Principles of Medical Ethics, relations with the United Mine Workers of America Welfare and Retirement Fund, the federal government's Medicare program, new standards for medical schools, a new statement on occupational health programs and the issue of Social Security benefits for physicians were among the wide variety of subjects acted upon by the House of Delegates at the American Medical Association's 106th Annual Meeting held June 3-7 in New York.

Dr. Gunnar Gundersen of La Crosse, Wis., member of the A.M.A. Board of Trustees since 1948 and chairman for the past two years, was unanimously chosen president-elect. Dr. Gundersen, who also was first chairman of the Joint Commission on Accreditation of Hospitals from 1951 to 1953, will become president at the June 1958 meeting in San Francisco. He will succeed Dr. David B. Allman of Atlantic City, who became the 111th president at inaugural ceremony in the Grand Ballroom of the Waldorf-Astoria hotel.

The House of Delegates voted the 1957 Distinguished Service Award to Dr. Tom Douglas Spies, head of the department of nutrition and metabolism at Northwestern University Medical School, Chicago, and director of the nutrition clinic at Hillman Hospital, Birmingham, for his outstanding contributions to the science of human nutrition.

GUIDES FOR RELATIONS WITH UMWA FUND

In a key action on the basic issue of third-party intervention, as it affects the patient's free choice of physician and the physician's method of remuneration, the House adopted the "Suggested Guides to Relationships Between Guides to Relationships Between State and County Medical Societies and the United Mine Workers of America Welfare and Retirement Fund," which were submitted by the A.M.A. Committee on Medical Care for Industrial Workers. In approving the guides, the House also recommended that the Board of Trustees study the feasibility and possibility of setting up similar guides for relations with other third-party groups such as management and labor union plans.

The statement, which outlines both medical society and UMWA responsibilities, contains these "General Guides":

"1. All persons, including the beneficiaries of a third-party medical program such as the UMWA Fund, should have available to them good medical care and should be free to select their own physicians from among those willing and able to render such service.

"2. Free choice of physician and hospital by the patient should be preserved:

"a. Every physician duly licensed by the state to practice medicine and surgery should be assumed at the outset to be competent in the field in which he claims to be, unless considered otherwise by his peers.

"b. A physician should accept only such terms or conditions for dispensing his services as will insure his free and complete exercise of independent medical judgment and skill, insure the

quality of medical care, and avoid the exploitation of his services for financial profit.

"c. The medical profession does not concede to a third party such as the UMWA Welfare and Retirement Fund in a medical care program the prerogative of passing judgment on the treatment rendered by physicians, including the necessity of hospitalization, length of stay, and the like.

"3. A fee-for-service method of payment for physicians should be maintained except under unusual circumstances. These unusual circumstances shall be determined to exist only after a conference of the liaison committee and representatives of the Fund.

"4. The qualifications of physicians to be on the hospital staff and membership on the hospital staffs is to be determined solely by local hospital staffs and by local governing boards of hospitals."

THE MEDICARE PROGRAM

The House considered three resolutions dealing with the federal government's Medicare program for the dependents of servicemen. The delegates adopted one resolution condemning any payments under the Medicare program "to or on behalf of any resident, fellow, intern or other house officer in similar status who is participating in a training program." Government sanction of such payments, the House declared, would give impetus to the improper corporate practice of medicine by hospitals or other nonmedical bodies. Such proposals, the House added, would violate traditional patterns of American medical practices, seriously aggravate problems of hospital-physician relationships, encourage charges by hospitals for residents' services to patients not under the Medicare program, and create a variety of additional problems in such areas as medical licensure and health insurance.

In another action on Medicare, the House recommended that the decision on type of contract and whether or not a fee schedule is included in future contract negotiations should be left to individual state determination. In this connection, however, the House restated the A.M.A. contention that: the Dependent Medical Care Act as enacted by Congress does not require fixed fee schedules; the establishment of such schedules would be more expensive than permitting physicians to charge their normal fees, and fixed fee schedules would ultimately disrupt the economics of medical practice:

The House also suggested that A.M.A. attempt to have existing Medicare regulations amended to incorporate the Association's policy that the practice of anesthesiology, pathology, radiology and physical medicine constitute the practice of medicine, and that fees for services by physicians in these specialties should be paid to the physician rendering the services.

NEW STATEMENT ON MEDICAL SCHOOLS

To replace the "Essentials of an Acceptable Medical School," initially approved by the House of Delegates in 1910 and most recently revised in 1951, the House adopted a new statement entitled "Functions and Structure of a Modern Medical School." Presentation of the document followed a year of careful study by the Council on Medical Education and Hospitals in collaboration with the Association of American Medical Colleges.

The statement is intended to provide flexible guides which will "assist in attaining medical education of ever higher standards" and "serve as general but not specific criteria in the medical school accreditation program." The document encourages soundly conceived experimentation in medical education, and it discourages excessive concern with standardization.

"No rigid curriculum can be prescribed for accomplishing the objectives of medical education," it states. "On the contrary, it is the responsibility of the faculty of each school continually to re-evaluate its curriculum and to provide in accordance with its own particular setting and in recognition of advances in science a sound and well-integrated educational program."

OCCUPATIONAL HEALTH PROGRAMS

The House also approved a new statement on the "Scope, Objectives and Functions of Occupational Health Programs," submitted through the Board of Trustees by the Council on Industrial Health. The Board report to the House said: "The statement describes and defines orthodox in-plant medical programs as understood in this

country today and distinguishes clearly between such programs and the various plans for comprehensive medical care of the sick. It should help to resolve misunderstandings concerning the specialty of occupational medicine."

In adopting the statement, the House agreed with a reference committee report which declared that "the House has before it a statement which for the first time clearly defines the scope, objectives and functions of occupational health programs. It marks the needs and boundaries of occupational medicine. It states in a positive fashion the proper place of occupational health programs in the practice of medicine and it clearly charts the pathways of communication between physicians in occupational health programs and physicians in the private practice of medicine."

SOCIAL SECURITY FOR DOCTORS

Two resolutions favoring compulsory inclusion of physicians in the federal Social Security system and another one calling for a nationwide referendum of A.M.A. members on the issue were rejected by the House. The delegates reaffirmed their opposition to compulsory coverage of physicians under the Old Age and Survivors Insurance provisions of the Social Security Act. They also recommended a strongly stepped-up informational program of education which will reach every member of the Association, explaining the reasons underlying the position of the House of Delegates on this issue. The House at the same time reaffirmed its support of the Jenkins-Keogh Bills.

MISCELLANEOUS ACTIONS

In considering 66 resolutions and many additional reports from the Board of Trustees, councils and committees, the House also:

Congratulated the Board and the Committee on *Poliomyelitis* for their prompt action in stimulating national interest in the polio immunization program;

Recommended further study and a progressive program of action, probably including legislative changes, to solve the problem of *narcotic addiction;*

Urged a more careful screening of television and radio patent medicine *advertisements;*

Directed the Board of Trustees to investigate the indiscriminate use of stimulants such as *amphetamine,* particularly in relation to athletic programs;

Directed the Speaker to appoint a committee of five House members to study the *Heller Report,* a management survey of the Association's organizational mechanisms;

Commended the Law Department for its special report on *professional liability* and urged state and county medical societies to establish claims prevention programs and to show the new film, "The Doctor Defendant";

Opposed the establishment of any further *veterans'* facilities for the cure of non-service-connected illnesses of veterans;

Condemned the compulsory assessment of medical men and staff members by hospitals in *fund-raising campaigns.*

OTHER ACTIVITIES

At the Monday opening session Dr. Dwight Murray, retiring president, stressed the triple theme of the personal touch in medicine, the necessity for freedom in medical practice and the need for professional unity. Dr. Allman, then president-elect, warned against the dangers of third-part contractual agreements involving fixed fee schedules.

Dr. Allman, in his Tuesday night inaugural address, declared that the physician is constantly striving for a balance between personal, human values, scientific realities and the inevitabilities of God's will. The inaugural ceremony, which was telecast over Station WABD-TV in New York, included presentation of the Distinguished Service Award to Dr. Spies.

ELECTION OF OFFICERS

In addition to Dr. Gundersen, the new president-elect, the following officers were selected by the House on Thursday:

Dr. Jesse Hamer of Phoenix, Ariz., vice president; Dr. George F. Lull of Chicago, secretary; Dr. J. J. Moore of Chicago, treasurer; Dr. E. Vincent Askey of Los Angeles, speaker, and Dr. Louis Orr of Orlando, Fla., vice speaker.

Four new members were elected to the Board of Trustees: Dr. George Fister of Ogden, Utah, to succeed Dr. James R. Reuling; Dr. Cleon Nafe of Indianapolis, to succeed Dr. James R. McVay; Dr. James Z. Appel of Lancaster, Pa., to replace the late Dr. Thomas P. Murdock, and Dr. Raymond McKeown of Coos Bay, Ore., to

replace Dr. Gundersen. Dr. Edwin S. Hamilton of Kankakee, Ill., was elected chairman of the Board at its organizational meeting after the elections in the House.

Dr. Homer L. Pearson Jr. of Coral Gables, Fla., was renamed to the Judicial Council. Two new members were elected to the Council on Medical Education and Hospitals: Dr. Clark Wescoe of Lawrence, Kan., to succeed Dr. Weiskotten, and Dr. Warde B. Allan of Baltimore, to succeed Dr. F. D. Murphy of Lawrence, Kan.

For the Council on Medical Service, Dr. Robert L. Navy of Detroit, was re-elected, and Dr. Hoyt Woolley of Idaho Falls, Idaho, was chosen to replace Dr. McKeown. Dr. Warren W. Furey of Chicago was re-elected to the Council on Constitution and Bylaws.

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Blue Shield's "Lost Generation"

Most Blue Shield Plans were born in the years 1938-45. Their creators, principally physicians, were determined to prove that medicine could create a medical prepayment plan that the public would accept. Also they were fired with an urgent challenge to turn back the threat of socialized medicine.

The labors of some of these pioneers in Blue Shield are legendary. They were "flying blind," over unknown and treacherous terrain. They were bucking strong headwinds of popular skepticism, official scorn and professional indifference. Many of these doctors devoted every hour they could spare from their practices to the missionary job of carrying the story of Blue Shield to every county society, every hospital staff meeting—to every place where they could get an audience of two or more doctors to listen to them.

These men created better than they knew. A prepayment movement that ten years ago numbered barely five million subscribers is now providing basic medical care security to forty million people. And the seventy-odd Blue Shield Plans count some 120,000 doctors as "participating physicians."

In the fifteen years that have elapsed since most Blue Shield Plans were founded, a whole new generation of doctors have come on the scene. For them, Blue Shield is only a part of the heritage of medicine bequeathed to this generation by those that have gone before.

This new generation knows nothing of the labors and sacrifices of their older colleagues in creating Blue Shield. Many of our younger brothers take Blue Shield for granted, and some do not even understand the vital differences between Blue Shield and the commercial insurance companies.

Of course, other factors, too, have distracted our attention from the problems of Blue Shield and dulled the edge of our concern for it in recent years. General prosperity among our patients has helped to assure us of collection of fees, and has given some of us the illusion that prepayment itself may no longer be needed.

The Plans, for their part, have been so preoccupied with enrollment activities that many have ignored the elementary needs of professional relations. Some have failed to maintain a constant flow of information to the doctor, and some Plans also have neglected to seek the guidance of the rank and file doctor before making changes in their programs.

Over and above all these factors lies the great blanket of complacency that has come upon us in recent years. Paradoxically, this complacency —the most serious threat to the future security and progress of Blue Shield—is, in large part, a consequence of Blue Shield's past success.

But the future is not as secure as the past. Blue Shield is the only segment of America's great health insurance program that has been shaped by our profession and is subject to our control. The time is past due for a revival of the crusading spirit that created Blue Shield, and is still needed if it is to complete the job it was intended to do for our patients, ourselves and our society.

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Dr. Derrick Vail Honored

Dr. Derrick T. Vail, professor and chairman of the department of ophthalmology in the Northwestern University medical school, was honored Tuesday, July 2 by members of the Oxford Ophthalmological Congress at Oxford, England, for his outstanding contributions to the field of ophthalmology.

A world-wide organization, the Oxford Ophthalmological Congress was founded in 1909 by Robert Doyne, a famous British ophthalmologist. Each year an international council invites an outstanding eye surgeon to deliver the Doyne

memorial lecture and to receive the Doyne medal. Dr. Vail is the second American in the history of the Congress to be so honored.

Subject of his address to the group was the zonule membrane, an important factor in cataract surgery. The lecture was given at Keble College of Oxford University.

During World War II, Dr. Vail was in charge of all eye work in the European Theater of Operations. He has received the Legion of Merit, the Bronze Star Medal, the Order of the Crown of Belgium, and the Medal of Gratitude from France. He is an honorary member of the Ophthalmological Society of the United Kingdom and an honorary fellow of the Royal College of Surgeons.

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Public Relations in past century

Our concern about public relations is nothing new. In 1882 Dr. Robert Boal of Peoria, one of the two men still living at that time who had sat in at the reorganization of the Society in 1850, was President of the Society. His President's Address was prepared to "contrast the past with the present—the then and now." He had the following to say on the subject: "A generation of human life has almost passed away since the few earnest and active members of the profession—twelve in number—in the library room of the old capitol in Springfield, organized our present association. To one who has lived through and witnessed it, the marvelous progress that has been made during the past fifty years in population, wealth, in science and the arts, in liberty, law and human rights, in a degree never before known in history, is a subject of unceasing interest and admiration . . . History contains no record of a people whose progress has been so rapid and marvelous as our own. The practice of medicine in all its departments was pursued by the same individual. Now we have specialists in every branch of the science and art of medicine . . . The amenities of professional intercourse and the obligations of medical men toward each other and the public, were then perhaps better observed than now . . . Then the doctor, next to the minister, was the trusted friend and counselor of every family to whom he ministered. He shared their joys, soothed their sorrows, and every passing year added to and cemented the attachment and affection between them. Now the doctor is regarded more in the light of a tradesman or mechanic, and is employed from the same considerations that a grocer, tailor, or shoemaker is. The strong ties of gratitude and affection have almost ceased to exist. Relationship is now placed upon a mere commercial basis, and for this the profession is more to blame than the public."

The subject continued to concern the Society and came up for discussion at various annual meetings. In 1893 Dr. E. Fletcher Ingals, President of the Society, suggested that the public be educated in matters affecting their health by circulars distributed through doctors' offices. The idea was studied for a year by a committee composed of Dr. Ingals, Dr. W. E. Guthrie of Bloomington and Dr. Sanger Brown of Chicago. At the meeting in 1894 this committee recommended that the work of educating the public in matters of health, avoidance of disease and habit-forming drugs, particularly cocaine, be carried on through a permanent committee. Dr. William E. Quine opposed this and suggested that the Society's committee cooperate with the Board of Health, which should carry on the instruction. His idea prevailed.

In the early 1920's the Educational Committee was created. For the first few years of its existence it was known as the Lay Education Committee. Its purpose was to place the doctor in a better light before the public. The name was changed to Educational Committee about 1928 and its work even at that time was largely of a medical educational nature. The Medical Service and Public Relations Committee has carried on this work in recent years.

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Medicine on postage stamps

Postage stamps of recent issue of interest to physician-philatelists include the following:

Brazil—2.50cr. stamp commemorating centenary of codification of Spiritualism shows bust of Allan Kardec, pseudonym of Hippolyte Leon Denisard, French doctor and scientist.

Colombia—Advice on longevity is given on 5c and 20c stamps issued in honor of world's reputed oldest man, Javier Pereira, said to be 167. The advice is: "Don't worry! Drink lots of coffee! Smoke a good cigar!"

Cuba—A 4e stamp honors nurse Victoria Bru Sanchez (1876-1918), who gave heroic service

in combatting influenza epidemic in 1918.

Dominican Republic—A 1c tuberculosis stamp issued April 1 was obligatory on all mail in April.

France—New Famous Men series includes two of medical interest: 12f pictures Antoine Beclere (1856-1939), pioneer radiologist; 18f shows Octave Terrillon (1844-1895), early worker in aseptic surgery.

Germany, East Zone—Jean Henri Dunant, founder of International Red Cross, is pictured on a two-value Red Cross set.

Indonesia—A set of six semi-postals carries a surcharge for the benefit of invalids and picture rehabilitation activities.

Jugoslavia—The usual Red Cross obligatory stamp and postage due show a silhouette of a mother and child in a Red Cross hostel. A striking series of nine stamps picture different medicinal plants.

Luxembourg—Three stamps honor the new Children's Hospital to be built in Luxembourg City.

Netherlands Antilles—A 15e stamp for the First Caribbean Mental Health Conference shows a man watching a rising sun.

New Zealand—A 3d stamp pictures Sir Truby King, founder of New Zealand's Plunket Society, which carries on infant welfare work.

Poland—Seven bi-colored stamps picture seven famous Polish physicians from the 16th to 20th centuries.

Switzerland—Five Pro Patria stamps bear a symbol of the Red Cross. The surcharge is for the benefit of the Red Cross Society, the National Cancer League and blind rehabilitation.

Turkey—A 25k stamp calls attention to the anti-tuberculosis campaign. An 80k stamp will be issued September 29 for the World Medical Association's 11th general assembly.

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Veterans of Foreign Wars elect physician commander

The Illinois Veterans of Foreign Wars at its annual meeting in Chicago, June 16, tossed out its commander who had waged war on the medical profession because of the A.M.A.'s stand that facilities of V.A. hospitals should be limited principally to veterans with service-connected disabilities.

Dr. Bernard E. Bolotoff, Rockford surgeon, won a landslide victory over John Englander, Chicago who had sought re-election.

Englander had campaigned vigorously against the A.M.A., and also had expressed concern over the fact that physicians were running for high V.F.W. offices in other large states. The veterans, by an overwhelming vote, decided they wanted no more of him.

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Why Physicians Should Not Be Under Social Security

FREDERICK W. SLOBE, M.D., CHICAGO

PHYSICIANS are humanitarians. Otherwise they would not have undertaken the practice of medicine. And they are not opposed to the humanitarian motives of certain aspects of social security.

It is believed, however, that the majority of physicians are right in their opposition to the compulsory inclusion of the medical profession under social security. Accordingly, the following discussion will endeavor to explain the basis for this conviction.

1. *The Social Security Act was enacted in 1935 to provide a floor of economic security primarily for retired workers of industry at age 65. It was intended particularly to help the lower income people, who were often among the indigent and who became objects of charity in their old age, to have a minimum guaranteed income after age of 65. It was enacted following the great depression and was designed to help those who had had long periods of low or no income during which time they had grown older and were approaching the unhirable age of 65. Gradually, the number of those covered has more than doubled to include nearly all those gainfully occupied. Many of these will never benefit even though they pay the tax.*
   (a) Most physicians do not come under the lower income category.
   (b) Very few physicians are ever objects of charity. Only 43 doctors and widows are current beneficiaries of the medical benevolence fund of the Illinois State Medical Society.
   (c) Physicians work for themselves and are not automatically cut off and prohibited from working for income at age 65 as are many people in industry.
   (d) There are always people who are ill and need physicians so that doctors, as a rule, can be productive in various ways and degrees until a ripe old age.
   (e) There are serious implications involved in inducing physicians to retire at 65. At present only one physician in seven retires between 65 and 75. And the sum total of medical knowledge and all available medical manpower should be utilized to the maximum. Physicians, as they grow older, usually adjust their activities and their patients recognize this. Besides, there is no scientific basis for retirement based on chronological rather than physiological age. Many of the greatest works have been accomplished by people over 65. Maturity of judgment and experience are often best manifested then. Retirement should be an individual matter.

Dr. Watson Gailey recently expressed the consensus among physicians quite well when he stated: "When I was 50 years old, I was thoroughly convinced that the physician of 70 should be retired with the label of 'old fogey.' I

have changed by mind. One is never too old to learn." Besides, as Harold Blake Walker emphasized so well, "When we coast we go down hill."

(f) Industrial employees under social security pay half the tax and the employer pays half but physicians will pay it all by themselves because they are self-employed.

2. *Under the Social Security Law those receiving social security, who are under the age of 72, may not earn more than $1,200 in any one year without some loss in benefits. There is this exception, however, in that payments may be available in months during which the beneficiary earns less than $80.*

(a) Physicians require many years of training before they are able to practice, and many are at the peak of their earning capacity when they reach 65. This may go on for years.

(b) Few physicians would be content to quit practicing, writing, consulting, engaging in medical administration or other medical relationships, in order to be eligible for social security payments. Sudden inactivity may be deadly for the physician, both physically and psychologically. They are accustomed to being productive and many have not developed hobbies. And, under social security, any appreciable productiveness is penalized as soon as it provides an annual income over $1,200.

(c) The young physician should be particularly wary. The younger the physician the less social security has to offer. He should ask himself "How much will $108 or $162 a month mean to me 40 years from now?" Remember, if he works after 65 he still pays taxes and if he earns over $1,200 he is penalized. He should remember he has about one chance in seven of retiring and that the chances are about 90 percent of what he pays in social security taxes for retirement will go to benefit others and only a small percentage will accrue to him.

And he should remember (as should all physicians) that he cannot collect both retirement and survivors benefits at the same time and that it would not be unlikely if he collected neither. Remember, to collect the retirement benefit he would have to live to, and retire at 65 (or become totally disabled at age 50), virtually quitting any gainful practice. As to survivors' (death) benefits, except when there are one or more dependent children, his widow would have to be 62 or over, she could not remarry, nor could she earn over $1,200 yearly without being penalized.

(d) Physicians paying in to the social security fund for years would thus derive little benefit from it in many instances.

3. *The trend is toward a continual expansion of federal intervention. One reason for this is that legislators are acutely conscious of the necessity for being re-elected, thus, they develop the habit of letting the future take care of itself. It was the influence of expediency, no doubt, which caused many to vote for the disability amendment to the social security law. Historically, most social security amendments have occurred during election years. This tendency should be warning enough.*

(a) It should be clearly understood that this is not "insurance" but a charitable governmentally controlled subsidy using the funds paid in by current participants[2]. The individual has no rights established by a contract, the benefits being by statute only, hence both the tax and the benefits can be changed by Congress at any time. Originally an annuity without survivorship benefits, it has developed into a pension. Participation is compulsory and cannot be dropped. How many physicians would take out an insurance policy in which the premiums could be increased and the benefits changed by the company at any time? Let us not confuse social security with War Risk Insurance which actually *is* insurance with fixed premiums and fixed benefits, under a contractual arrangement. There seems to be little doubt that many of the younger

2 Richard C. Webster, M.D. and Richard J. Coffey, M.D.: Social In-Security — J.A.M.A., September 15, 1956

doctors who seem to favor inclusion under social security do so because they mistakenly consider it to be cheap "insurance."

No one knows how high the tax or what the benefits will be in the future. Physicians tempted should remember that the chances of most physicians or their dependents collecting the indicated benefits are remote indeed. If so-called "present" taxes are sufficient for future demands, why is the tax rate increased periodically? True insurance was never like this.

(b) The heart of the scheme is compusion. If physicians are included under the Act, every doctor will be taxed if he earns over $400 per year, even if he has no dependents. And we should consider whether compulsory government insurance may not be the forerunner of compulsory government medicine.

(c) It is required that all people be forced to pay, good risks as well as poor ones.

(d) The so-called social "insurance" as embodied in social security calls for the government to come to the aid of everyone in all the normal risks of life.

(e) Thus, with the government providing protection as a matter of right and compulsion, the individual is taught to rely upon the state in areas where self-reliance has always been considered the basis of our society.

(f) This in essence is the cradle to the grave security system and is closer to the grave than to the cradle. It can turn our nation into a socialistic state in which the planners tell us there will be no need to look after ourselves, nor to work and plan for the future. Old Age Assistance, instead of diminishing following the advent of social security, has increased steadily.

4. *If we look deeper, we can see another hidden danger. The welfare state will catapult us into a full compulsory health insurance and medical care program, with physicians caught in the vise of socialized medicine. The recently adopted total disability at age 50 amendment to the Social Security Law is another step in this direction.*

Let us review the history of the fellow travelers and the socialistic International Labor Organization. That organization in Geneva in 1952, adopted seven minimum standards of social security, all of which except the last three, have in some measure come to pass here. And a bill was introduced in the last legislative session pertaining to one of these three.

It has been estimated that, if all the points of the International Labor Organization were adopted here it might involve 35 percent of payroll. In the past five years the tax base, that is, the maximum earned income on which you would be taxed, has increased by 40 percent. If this rate is maintained the maximum income taxed would reach $9,000 by 1975. If by that time the tax is increased to 6 percent, as in the present law, the annual tax will reach $540.

I think that most citizens believe as I do — that the social security system has certain merit and that there are legitimate activities, involving health and welfare, in which the federal government may be engaged, but if they believe the system is sound, they should be alert to the attempts to use or abuse it in the name of politics. Ill considered schemes to expand or broaden the scope of the social security program should be exposed for what they are.

5. *How do physicians personally feel about being included under the Old Age Security benefits of the Social Security Act? That is a personal question which can only be interpreted by the individual self-employed person as it applies to his own situation and in view of the inherent dangers of the social security system. One physician has expressed the view that he took the oath of Hippocrates as a young man, there was no time limitation on the vow to serve mankind. There was no provision to retire at the age of 65. He said he took the oath for life and serve he would until the breath of life was no longer in him. Many physicians feel the same way.*

(a) Those who have the intelligence to become physicians have the intelligence to retire on a program based on their own planning and initiative.

(b) A governmental program involving compulsion is repugnant to members of a highly individualized profession.

(c) Cost is a major consideration. Advocates of the program of a so-called ideal social security system planned in Switzerland may not have known what its future cost would be. Here are the shocking figures. In France a similar program caused financial chaos. The tax rate absorbs 35% of much of their payroll and is one of the principal reasons for the failure of the French economy to make a post-war comeback.

So it seems vitally important that we as Americans consider that the estimated ultimate cost of the whole program, ultimately might reach 30% of payroll as a minimum and could cost as much as 40% of taxable payroll if the experience of certain other countries is duplicated here.

We as taxpayers must realize that with a mounting aged population, the costs of the social security program here will continue to climb.

When you consider that fact that 9 out of 10 of the nation's labor force are now included under old age security insurance through enactment of major amendments in the past five years, it becomes crystal clear that the cost involved will reach staggering proportions.

6. *And what is the social security program cost?*

Of course expansion of the system is reflected in the increase in the tax base, namely the amount of income which would be taxed. In 1937, the level was $3,000. In 1954, it climbed to $4,200. The rate of taxation also has seen periodic increases. In 1937, the tax was 1% of payroll for employee and employer — in 1950, 1½%, and in 1954 it became 2%.

7. *And what will physicians pay as individuals?*

COMPARATIVE TABLE TAX RATE

	Employee	Employer	Self-Employed
1957-1959	2¼%	2¼%	3⅜%
1960-1964	2¾%	2¾%	4⅛%
1965-1969	3¼%	3¼%	4⅞%
1970-1974	3¾%	3¾%	5⅝%
After 1975	4¼%	4¼%	6⅜%

8. *What can you do with that amount of money if you invest it in government bonds — in gilt edged stocks?*
9. *And if you don't take advantage of social security at 65 what will it have cost you? Remember, there are no benefits if you don't retire.*
10. *What alternative methods are there for physicians who wish financial protection for their families and their own old age?*

(a) For the young physician

Life insurance with a family income rider furnishes fine protection.

For example, let us take a physician, aged 30, with 2 children, one newborn and one 2 years old.[3] A $20,000 life insurance policy with a 20 year family income rider, will pay his widow if he dies within 20 years, $200 a month until his baby is 20 years old, at which time his widow would receive a lump sum of $20,000 or installments as contracted. The annual premium would be about $498. If he lives for 20 years the insurance is retained, the annual premium being reduced about 20 percent. And, if he maintains this coverage until 65 and leaves his dividends he can withdraw a total of $18,160 at that time if he wishes.

For example, a decreasing term life insurance contract will give protection equivalent to an invested capital at the start of about $31,000, for a premium of only $98 a year (for the family income rider only). Similar protection under social security would cost him $141 a year at present rates, with no telling how much the tax will be increased later. Similarly, at age 40, the family income rider would be needed for only 10 years, assuming his children are about 10 years old and this would cost only about $60 a year.

(b) Other well known insurance facilities are available. Benefits are flexible; they may be paid in a lump sum or in installments; paid up policies, cash value, or loan security are available; also riders for double indemnity for accidental death or with waiver of premium for disability; provision for paying mortgages; disability income riders; payment of dividends; retirement annuities — these are but a few examples of the flexibility offered.

(c) The Jenkins — Keogh Bill, which failed to pass in the last Congress,

3 Robert H. Jordan and Harry E. Ungerleider: Life Insurance for the Young Physician; J.A.M.A., October 27, 1956

would have enabled physicians and other self-employed to take an income tax deduction for contributions made to a retirement fund. Similar legislation to furnish retirement annuities should be supported by the medical profession in the next Congress.

The American Bar Association, no doubt, will continue its support for this legislation.

(d) Sponsorship by the state medical societies of various programs including group life insurance, disability insurance, hospitalization coverage, retirement income plans and the like.

If the profession is opposed to inclusion under compulsory social security, their constituent societies should exhibit energetic leadership in helping supply a desirable substitute at favorable cost. With this, should go a continuous campaign emphasizing the desirability of embarking on a planned program.

Important, too, are provisions against cancellation of hospitalization insurance or certain other benefits at a certain age or due to some other eventuality.

(e) Augmentation of the Benevolence Fund of the State Society might be considered. This pays up to $75 monthly to a physician or his widow.

The questions we have tried to answer, in the last analysis, must be answered by all physicians for themselves. However, it behooves all of us to take a good look at social security both for ourselves and for our nation. Above all, let us watch it carefully, let us use our influence to direct it so that it may not lead us down the road of the welfare state — compulsory health insurance and socialized medicine. In many countries the only choice seems to be between totalitarianism and the welfare state. American physicians can be proud of their resistance to both.

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The medical team

Today, medicine is like the football team that lacks one essential player. And that missing player is that apathetic individual who thinks the victory can be his without participation. This medical team wants to win against sickness and disease, but all individuals must be willing to carry their responsibilities. We in medicine can block for the individual if we would only take the ball and run with it. We can run with the ball for the individual if he would only let us. And we can pass the ball to him if he would only become the receiver. Until every individual takes his place, medicine cannot be the best possible team. Until we have every individual working with the medical team, we are going to have a tough time getting across the goal line. To achieve victory the individual cannot sit on the bench. Nor can he play the game alone without medicine. *Dwight M. Murray, M.D. Who's Responsible for Health? New York J. Med. May* 1, 1957.

The 1957 Annual Meeting

With a total registration of 3,306, the meeting was considered a successful one. Once again it was held at the Sherman Hotel in Chicago. If you missed attending, here is a pictorial report on some of the events:



Annually, the big feature of the closing session of the House of Delegates is the induction of the new president. F. Lee Stone (left) is shown preparing to hand over the official gavel to our new president, Lester S. Reavely of Sterling. Dr. Reavely brought Mrs. Reavely to the platform to share the honors.



When Raleigh C. Oldfield, Oak Park (left) became president-elect, Harry J. Dooley, also of Oak Park, succeeded him as councilor for the Third District.



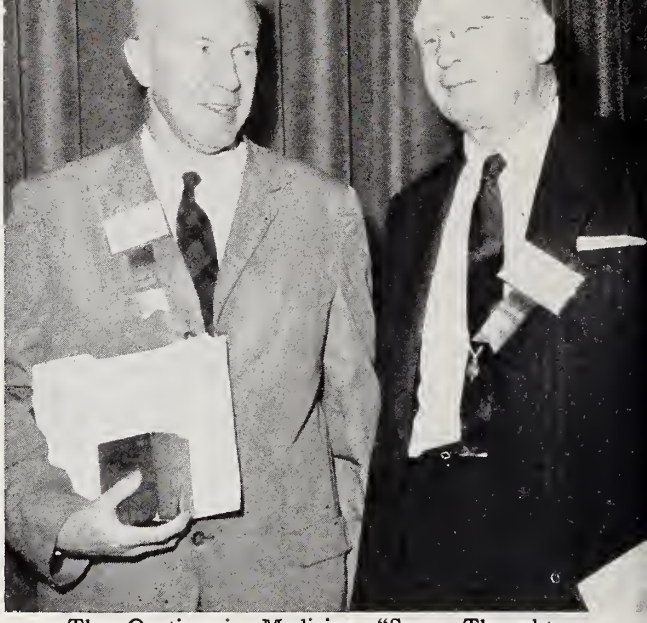
Newton DuPuy of Quincy is the new councilor for the Sixth District, replacing Warner H. Newcomb of Jacksonville.



A highlight of the 29th annual meeting of the Women's Auxiliary was a luncheon address by Dr. Nicholas Nyaradi, former Minister of Finance in Hungary, whose subject was "The Fifth Freedom". He is shown above with Mrs. Nicholas G. Chester (left) the new Auxiliary president, and Mrs. Robert E. Dunlevy, the retiring president.



The Oration in Surgery was delivered by William F. Mengart, Chicago. His subject was "Terminal Care".



The Oration in Medicine, "Some Thoughts on Specialization in Medicine" was given by William B. Bean, (left) Iowa City, Iowa. J. J. Moore, Treasurer of the American Medical Association, congratulated Dr. Bean at the conclusion of his address.



The member traveling the greatest distance to attend the meeting was Elva W. Calvert of Pine Castle, Florida, shown (left) with Mrs. Calvert. Harold M. Camp, the Society's secretary, welcomed the Calverts at the registration desk.



At the Fifty Year Club luncheon Mrs. Beatrice Gilmore was inducted into the club by Andy Hall. W. H. Alvis (left) offered his congratulations.

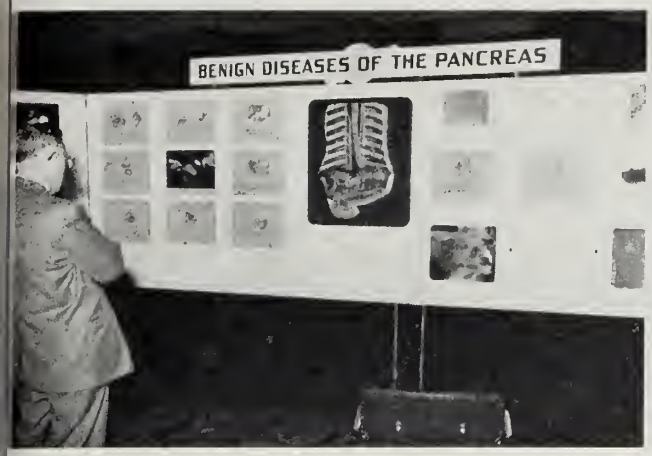


One of the groups at the Fifty Year Club luncheon is pictured above. They are: R. L. Green, Mrs. L. M. Coffey, L. M. Coffey, all of Peoria, R. G. Dakin, Sandwich, J. L. Barnsback, Chicago, William Cooley, A. A. Knapp, and Miss Mary L. Knapp, of Peoria.



The Public Relations Dinner on Tuesday evening drew a large and enthusiastic crowd. The principal speaker was Mr. Paul Jones, Director of Public Information of the National Safety Council.

Exhibits



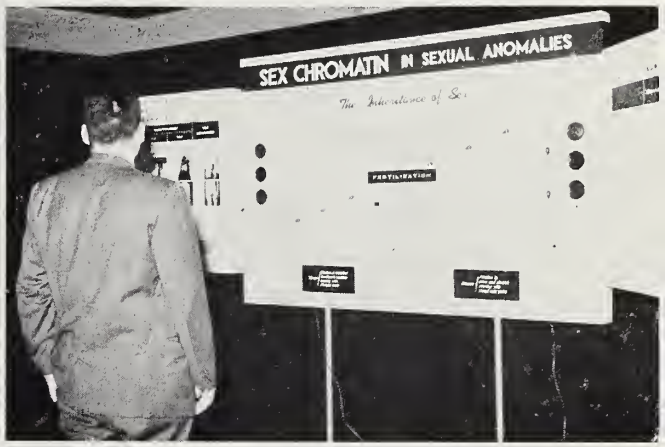
In the educational class of the Scientific Exhibits the gold medal went to Charles B. Puestow and W. J. Gillesby of the Veterans Administration Hospital at Hines.



The silver medal for educational value went to Julius E. Ginsberg and Bruce Bairstowe of Northwestern University Medical School. The title of the exhibit "Alopecia Capitis General Etiologic Survey".



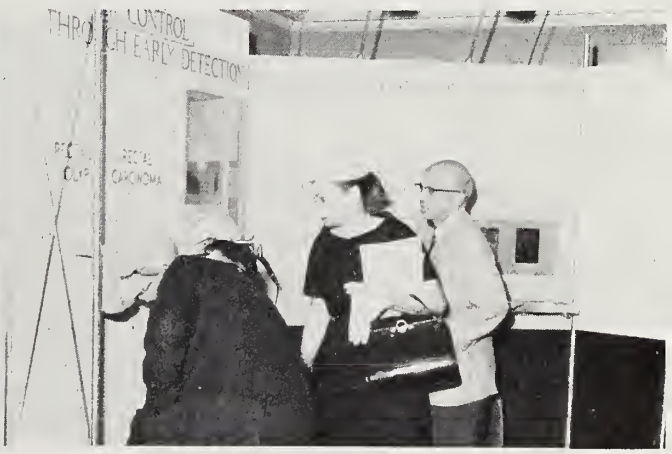
The gold medal in the original work classification went to Steven O. Schwartz, H. M. Schoolman, P. B. Szanto, Wilma Spurrier and LeRoy Yates, at the Hektoen Institute. The exhibit was titled "The Viral Etiology of Leukemia".



The bronze medal for original work was presented to Joseph H. Kiefer, Ira Rosenthal, Elizabeth McGrew and I. Pat Bronstein. The exhibit was titled "Sex Chromatin in Sexual Anomalies".



Medical exhibitors were pleased with the interest and time visitors gave to studying new products. Shown above is a view of the Pfizer Laboratories exhibit.



The Cancer Prevention Center of Chicago drew a steady procession of interested viewers.

THE P. R. PAGE

Edward A. Uzemack, Director of Public Relations

" . . . It is our responsibility to minister not only to the human body and its ills — but also to human hearts, minds and emotions . . ."

David B. Allman, M.D.
President, American Medical Association

THERE have appeared in recent weeks a number of news items pointing up the fact that good medical public relations cannot be attained through intravenous injection or osmosis.

Case Number One involves a man who, in the eyes of the press, became a hero in the noblest tradition of the medical profession. A few weeks later the hero's laurel was torn from his head by the same newspapers, whose headlines screamed the accusation that he was a mercenary.

Case Number Two involves a man who also gained national press attention for upholding the traditions of medicine. His deeds of mercy at the scene of one of the nation's worst hurricane disasters involved a personal ordeal which showed him to be endowed with extraordinary fortitude.

Case Number Three involves a country doctor whose passing went unnoticed in most of the nation's press, but whose simple, every-day observance of the Hippocratic Oath and the Principles of Medical Ethics won for him the undying adoration of his community. In eulogizing this great doctor, the editor of the local newspaper wrote:

". . . His interest in his patients was something greater than professional. He had a deep personal interest in everything that touched the lives of those with whom he came in contact.

"He loved his family and they shall be protected by the happiest of memories. He loved his church, his profession and his community and was loyal to each of them. It can be said of him as was said of old in regard to the Great Physician, "He went about doing good . . ."

To go about doing good is an over-simplified expression of the principles of public relations. Yet the business of doing good, being good and telling the world about it is what public relations boils down to.

But a lot can go wrong with the public relations of individual physicians or medical societies if exercised only subconsciously. The effort must be voluntary and deliberate. Only then can you be certain that what you tell the world, or the world is told about you will be good.

AMA's Public Relations Institute

There is still time to plan your attendance at the annual Public Relations Institute of the American Medical Association August 28 and 29 at Chicago's Drake Hotel. Your Public Relations Director will participate in a demonstra-

tion entitled, "PR Man On A Hot Tin Roof." This skit will be part of a one hour session on medical society press relations.

This year's program, as usual, will be pertinent and of much value to PR committee chairmen, secretaries and other officers of county medical societies. We are fortunate in Illinois that this annual event is held so close to our respective homes.

Hotel reservations can be obtained either directly through the Drake, where a block of rooms is customarily reserved for Institute participants, or the Public Relations office of the Illinois State Medical Society, 185 North Wabash Avenue, Chicago 1, Illinois. The phone number here is FInancial 6-0443.

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Antibiotic combinations

Normal human subjects were given, in random rotation, single oral doses of 500 mg. and 1,000 mg. of penicillin V or tetracycline hydrochloride or equal amounts of both. The doses were each given before breakfast, several days apart, each subject receiving six different doses. Blood was obtained before and at the same intervals after each dose, over a period of 24 hours, and the plasmas were tested for antistreptococcal and antipneumococcal activity. For each total dose, penicillin V yielded the highest peak level of antistreptococcal and antipneumococcal activity, and tetracycline the lowest, and the pair yielded intermediate values. The total antistreptococcal activity estimated over the 24 hour period likewise was greatest after penicillin V, lowest from tetracycline, and intermediate for the pair. However, the total antipneumococcal activity resulting from the tetracycline was greater than that derived from the same total amount of the pair of antibiotics and, after the 1,000 mg. dose of tetracycline, also was greater than that derived from this amount of penicillin V. Most of the differences observed in the maximum inhibiting concentrations were statistically insignificant, but the differences in the total activity were not. At each interval after the various doses, the level of both antistreptococcal and antipneumococcal activity produced in the plasma by the pair of antibiotics was lower than that resulting from the same dose of one or the other single agent. During the first few hours, penicillin V produced the greatest activity and, thereafter, the highest values were obtained from the tetracycline. *Wilfred F. Jones, Jr., M.D. and Maxwell Finland, M.D. Antibiotic Combinations. New England J. Med. May 9, 1957.*

CORRESPONDENCE



O. & G. board certifies

The American Board of Obstetrics and Gynecology announced the following certifications of Illinois physicians were made May 25:

Drs. John A. Aimone, Berwyn; Victor M. Bowers Jr., Rockford; Charles D. Collins, Chicago Heights; Donald M. Fahrenbach, Chicago; William J. Farley, Peru; David Friedman, Granite City; Allwyn H. Gatlin, Evanston; Raphael S. Good, Chanute Air Force Base; Ephriam A. Grier, Chicago; Bernard M. Kaye, Highland Park; Peter J. Kearney, Lake Forest; Charlotte H. Kerr, Chicago;

Also Drs. Edwin M. McGill, Evanston; George G. Moran, Downers Grove; Charles W. Moulton, Olney; Ernest G. Nora, Chicago; Frank P. Paloucek, McHenry; Marvin A. Rosner, Chicago; Natalie Stephens, Chicago; David D. Turow, Chicago; Jerome Warren, Park Forest; Walter F. Watts, Chicago, and Seymour D. Wishnick, Chicago.

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World-renowned surgeons on I.C.S. annual congress

World-renowned surgeons from five continents will appear on the scientific program of the 22nd annual Congress of the United States and Canadian Sections, International College of Surgeons, in the Palmer House, Chicago, September 8-12.

Among foreign surgeons presenting papers will be:

Prof. Dr. Mario Battezzati, director of the Institute of Pathologic Surgery, University of Parma, Italy.

Prof. I. Boerema, professor of surgery, University of Amsterdam, The Netherlands.

Dr. Masao Fujimori, professor of surgery, Kimoto's Surgical Department, School of Medicine, Tokyo University.

Prof. Dr. Francisco Graña, former head of the department and professor of surgery, San Marcos University, Lima, Peru.

Dr. Henri Laborit, director of experimental and clinical research, Army Research Center, Val de Grace, Paris, introducer of hypothermia.

Prof. Dr. Juan Netto, professor of clinical surgery, Faculty of Medicine, Asuncion, Paraguay.

Prof. Dr. César A. Pantoja, National University of Bogota, Colombia.

Dr. A. K. Saha, Hunterian Lecturer at the Royal College of Surgeons of England and professor of surgery, Nilratan Sircar Medical College, Calcutta.

Prof. John Charnlet of the Royal Infirmary, Manchester, England.

Dr. Ph. Polani, chief radiologist, l'Hospital Israelite, Alexandria, Egypt.

Prof. Dr. Shigeru Sakakibara, professor of surgery, Tokyo Women's Medical College.

Prof. Dr. José Soler-Roig, University of Barcelona, Spain.

Prof. Dr. Jorge Taiana, former professor of surgery and dean of the Medical Faculty, University of Buenos Aires.

Dr. Kazumi Taguchi, assistant professor of surgery and chief of the cardiac division, Okayama (Japan) University Medical School.

Prof. Dr. Alfonso de la Fuente, professor of surgical pathology, Faculty of Medicine, University of Madrid.

Dr. Marc Iselin, member of the Academy of Surgery, Paris.

Distinguished American and Canadian surgeons also will be on the program, which will consist of General Assembly sessions and meetings of coloproctologic surgery, neurosurgery, obstetrics-gynecology, occupational surgery, ophthalmology-otolaryngology, orthopedic surgery, plastic and reconstructive surgery and urologic surgery sections.

Dr. Raymond W. McNealy, Chicago, is general chairman of the Congress, with Dr. Karl A. Meyer, Chicago, and Dr. Richard M. H. Power, Montreal, as co-chairman.

Additional information may be obtained from Dr. Ross T. McIntire, executive director, International College of Surgeons, 1516 Lake Shore drive, Chicago 10.

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Clinics for crippled children listed for September

Twenty four clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois, Division of Services for Crippled Children. The Division will count 18 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing service. There will be 3 special clinics for children with cardiac conditions, 1 for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The September Clinics are:

September 4 — Carmi, Carmi Township Hospital

September 4 — Hinsdale, Hinsdale Sanitarium

September 4 — Rock Island (Cerebral Palsy), Foss Home 3808 - 8th Ave.

September 5 — Clinton, Christian Church

September 5 — Sterling, High School Field House

September 10 — East St. Louis, St. Mary's Hospital

September 10 — Peoria, Children's Hospital (St. Francis)

September 11 — Joliet, Will County T.B. Sanitarium

September 12 — Anna, County Hospital District

September 12 — Springfield, St. John's Hospital

September 13 — Chicago Heights Cardiac, St. James Hospital

September 17 — Alton, Memorial Hospital

September 18 — Centralia, Recreation Center

September 18 — Elmhurst Cardiac, Memorial Hospital of DuPage Co.

September 18 — Evergreen Park, Little Company of Mary Hospital

September 18 — Springfield (Cerebral Palsy), Memorial Hospital

September 19 — Rockford, St. Anthony's Hospital

September 24 — Effingham (Rheumatic Fever), St. Anthony Hospital

September 24 — Peoria, Children's Hospital (St. Francis)

September 25 — Aurora, Copley Memorial Hospital

September 25 — Jacksonville, Our Savior's Hospital

September 26 — Decatur, Decatur-Macon County Hospital

September 26 — Sparta, Sparta Community Hospital

September 27 — Chicago Heights Cardiac, St. James Hospital

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Refresher in aviation medicine

A refresher course in aviation medicine, designed for physicians and others interested in health and safety in flying will be presented at the Health Center, Columbus, O., September 9-13.

The course is sponsored by the Ohio State University College of Medicine and Medical Di-

vision, Civil Aeronautics Administration. Basic information will be brought up to date but chief emphasis will be upon new material not previously covered. The registration fee is $75.

Further information may be had by writing to Dr. William F. Ashe, Department of Preventive Medicine, Ohio State University Health Center, Columbus 10, O.

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10,000 attendance expected at A.C.S. clinical congress

More than 10,000 physicians, medical students and related medical personnel are expected to attend the 43rd annual Clinical Conference of the American College of Surgeons in Atlantic City, October 14-18.

About 1,000 will take part in the program as authors of papers or participants in symposia, panels, motion picture showings and TV presentations.

The program will include postgraduate courses, discussions in general surgery and surgical specialties, motion pictures, cine clinics, color television from Johns Hopkins Hospital, Baltimore, research reports and scientific and technical exhibits.

Major addresses will be given by Dr. William L. Estes Jr., Bethlehem, Pa., incoming president of the College; Dr. Harrison L. McLaughlin, New York, who will give the Oration on Trauma, and Dr. Ernest B. Verney, Cambridge, Eng., who will present the annual Baxter Lectureship.

Initiates for fellowships and honorary fellowships will be inducted on October 18, and officers will be inaugurated.

Medical students from 36 medical schools, including Chicago, will attend the Congress as College guests. The student participation program was launched last year as an educational contribution.

Dr. J. Garrott Allen, University of Chicago, and Dr. Henry T. Bahnson, Johns Hopkins University, Baltimore, are in charge of the television program. Among other chairmen is Dr. Hilger P. Jenkins, Chicago, who is in charge of the motion picture presentations.

Headquarters for the Congress will be in Convention Hall. Some sessions also will be held in nearby hotels.

Chicago Heart Association conference

The Chicago Heart Association will sponsor a conference on the pulmonary circulation to be held Thursday, Friday and Saturday, March 20 to 22, 1958, at the Palmer House.

Introductory sessions will be devoted to the physiology, anatomy and pathology of the pulmonary circulation with special emphasis on methods of clinical study. Later sessions will cover the pulmonary circulation in congenital heart disease, primary lung disease and in acquired heart disease.

Among the distinguished visitors who are accepting major responsibilitiy in the planning and execution of the conference are Dr. Julius Comroe, University of Pennsylvania Graduate School of Medicine, Dr. Howard Burchell and Dr. Jesse Edwards of the Mayo Clinic, Rochester, Minnesota, Dr. Paul Wood for the Institute of Cardiology, London, and Dr. Lars Werko of Goteborgs Universitet, Gothenburg, Sweden.

It is the objective of the conference to bring together major contributors to this controversial field. Each participant will present his own recent work and opportunity will be provided for discussion. The meeting will be open to physicians and scientists.

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American Board of Obstetrics and Gynecology

Applications for certification (American Board of Obstetrics and Gynecology), new and reopened, for the 1958 Part I Examinations are now being accepted. All candidates are urged to make such application at the earliest possible date. Deadline date for receipt of applications is September 1, 1957. No applications can be accepted after that date.

Candidates for admission to the Examinations are required to submit with their application, a typewritten list of all patients admitted to the hospitals where they practice, for the year preceding their application, or the year prior to their request for reopening of their application. This information is to be attested to by the Record Librarian of the hospital or hospitals where the patients are admitted and submitted on paper 8½x11″. Necessary detail to be contained in the list of admissions is outlined in the Bulletin and must be followed closely.

Current Bulletins outlining present requirements may be obtained by writing to the Secretary's office.

Robert L. Faulkner, M.D.
American Board of Obstetrics and Gynecology
2105 Adelbert Road
Cleveland 6, Ohio

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Films available for professional audiences

Five new firms available for showing to professional audiences are announced by the National Foundation for Infantile Paralysis. They are designed to interest physicians, nurses, physical therapists, occupational therapists and students of all professional schools.

(1) Rehabilitation of Respiratory Patients — 1957 — BW — Sound — 16mm — 12 minutes

The film presents the basic philospohy behind the programs of patient care, teaching and research as developed by the respiratory and rehabilitation centers. The film was produced by the National Foundation in cooperation with the patient and staff of the Respiratory Center for Poliomyelitis, Ann Arbor, Michigan.

(2) Principles of Artificial Respiration — 1957 — Color — Sound — 16 mm — 29 minutes

The film uses normal subjects, patients and models to illustrate the basic physiological principles necessary to evaluate various types of manual and mechanical artificial respiration. The film was produced by the National Foundation with the aid of a committee of researchers and clinicians from the Harvard School of Public Health, Boston, Massachusetts.

(3) Assistive Devices for the Physically Handicapped — 1957 — Color — Sound — 16 mm — 12 minutes.

The film was produced by the National Foundation in cooperation with the Mary MacArthur Poliomyelitis Respiratory Center, Wellesley Hills, Massachusetts, the Southwestern Poliomyelitis Respiratory Center, Houston, Texas and the Poliomyelitis Respiratory Center, Columbus, Ohio. It demonstrates various kinds of assistive devices used to increase the functional capacity of the physically disabled from such simple equipment as mouth stick to electric wheel chair.

(4) Muscle Breathing Patterns in Poliomyelitis — 1956 — Color — Sound — 16 mm — 15 minutes.

Produced under a grant from the National Foundation by the Respiratory Center for Poliomyelitis, Hondo, California, this film uses normal subjects, patients and animation sequences to demonstrate various types of muscle breathing patterns encountered in poliomyelitis patients.

(5) The Anatomy of the Hand - Part II — 1956 — Color — Sound — 16 mm — 30 minutes.

The film uses dissections and models to demonstrate the structures of dorsal surface of the hand. The film was produced by the Department of Anatomy, Duke University of Medicine under a grant from the National Foundation.

PART I of this film — 1956 — Color — Sound — 16 mm — 32 minutes was produced earlier in the year and is still available. The film demonstrates the structures on the volar surface of the hand which are superficial to the palmar spaces. Also produced in cooperation with Duke University School of Medicine.

Three weeks' advance booking is requested for films.

Write to:
Division of Professional Education
National Foundation for Infantile Paralysis
301 East 42nd Street
New York 17, New York

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New film on peripheral vascular disease available

Arlington-Funk Laboratories, a division of U.S. Vitamin Corporation, New York, N.Y., has just released a new, educational, clinical film titled, "Peripheral Vascular Disease — Physiology and Efficacy of a New Therpeutic Agent". The 16 mm. motion picture, in full color and with sound, runs for 32 minutes. It is available for showing to all medical organizations, including state, county and local. Arrangements for showing the film can be made by writing to either Arlington-Funk Laboratories, division of U.S. Vitamin Corporation, 250 East 43rd

Street, New York 17, N.Y., or Medical Film Guild, Ltd., 506 West 57th Street, New York 19, N.Y.

The film was produced with the cooperation of research workers at Boston University, Montefiore Hospital, New York Medical College, Lemuel Shattuck Hospital, St. Vincent's Hospital and other Universities.

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List of newly elected society officers

Chicago Urological Society

At the annual meeting held April 11, 1957, the following officers were elected:

President: J. Lester Wilkey, M.D.
Vice-President: Don E. Murray, M.D.
Secretary-Treasurer: David Presman, M.D.
104 S. Michigan Avenue

Chicago Neurological Society

Annual meeting held May 21, 1957.

President: Oscar Sugar, M.D.
Vice-President: John Madden, M.D.
Secretary-Treasurer: Meyer Brown, M.D.
636 Church St., Evanston
Councilor: Irving Sherman, M.D.

Chicago Psychoanalytic Society

Annual meeting held March 26, 1957

President: Joan Fleming, M.D.
President-elect: Therese Benedek, M.D.
Secretary: Joseph G. Kepecs, M.D.
111 N. Wabash Avenue
Treasurer: Samuel D. Lipton, M.D.
Representative to Executive Council American Psychoanalytic Association: Herman Serota, M.D.
Alternate Representative: Hyman Fingert, M.D.

Chicago Society of Internal Medicine

Annual meeting held May 27, 1957

President: Howard Wakefield, M.D.
Vice-President: Ernest G. McEwen, M.D.
Secretary-Treasurer: Franklin A. Kyser, M.D., 636 Church St., Evanston, Ill.

Chicago Gynecological Society

Annual meeting held June 21, 1957

President: A. F. Lash, M.D.
President-elect: H. Close Hesseltine, M.D.
Vice-President: Augusta Webster, M.D.
Secretary: William G. Cummings, M.D.
636 Church St., Evanston
Assistant Secretary: Joseph B. Teton, M.D.
Treasurer: Walter F. Dillon, M.D.

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Chicago Pediatric Society solicits papers

All those desiring to present papers before the Society during the coming year, will be welcome to submit title and brief resume of subject matter before August 15, 1957.

The November Meeting will be a Memorial to Dr. Stanley Gibson to be given with the Alumni of Children's Memorial Hospital. Dr. Helen B. Taussig, of The Johns Hopkins Hospital, Baltimore, Maryland, will present the scientific portion of the program.

The regular meetings are held the third Tuesday of each month, October through April in the Auditorium of the Nurses Home, Children's Memorial Hospital.

Raymond F. Grissom MD
Secretary

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American College of Chest Physicians

The following Illinois physicians received their certificates of Fellowship in the American College of Chest Physicians at its recent meeting in New York City:

Maurice Berger, Donald Cassels, Joseph R. Christian, Robert F. Dillon, E. H. Fell, Bessie L. Lendrum, Frederick M. Lindauer, and Robert A. Miller all of Chicago;

Dr. Otto L. Bettag of Chicago was re-elected to the Board of Regents of the College, and Dr. Darrell H. Trumpe of Springfield was re-elected Governor of the College for Illinois.

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German Medical Society of Chicago

At the last meeting of the German Medical Society of Chicago, held June 24, 1957, the following officers were elected for the year 1957-1958: President, Ferdinand Seidler; Vice-President, Joseph R. Mueller; Secretary, Eugene F. Lutterbeck; Treasurer, Edward V. Stalzer. Board of Directors: Hans Deutsch, Joseph Gandy, Paul H. Holinger, Fidelius Knoepfler, Lydia Walkowiak.

AT THE EDITOR'S DESK



SIR Winston Churchill gave his formula for good health at 81: "A lot of drinking, a lot of eating and eight or nine hours of sleep most of it in the daytime."

There are few drugs that have received as much publicity as Miltown. It is a product of Wallace Laboratories, a division of Carter Products, Inc.

The latter manufactures and sell Carter's Little Liver Pills that are said to "wake up your liver bile." Wyeth also buys Miltown from Carter and sells it under their own label as Equanil. The organization is financially successful and filed recently a registration statement with the Securities and Exchange Commission in order to place 500,000 shares of stock on the market. It is expected that these shares will be snapped up by the Wall Street brokers who were said to thrive on Miltown. We hope that the results will prove as beneficial for their pocketbooks as Miltown has been for their nerves.

Winthrop Laboratories reports that fifty patients with rheumatoid arthritis were relieved with their anti-malarial drug, Aralen. No toxic effects were noted even though 300 mg. were administered daily for two years.

An unusual experiment is being conducted on a colony of forty rabbits at the VA hospital in Dallas. Each rabbit spends three hours in a plastic box and smokes the equivalent of a pack of cigarettes a day. All together they will smoke more than 1,600,000 cigarettes during their five-year normal life span. Most of the rabbits enjoy it and take their puffs with obvious relish. It is hoped that the experiment may help to answer the question of whether cigarettes are a cause of lung cancer.

A unique operation was performed recently at the VA hospital in Cleveland on a veteran who lacked tears. The parotid duct was transplanted in order to change the flow of saliva from the mouth to the eyes. The operation was a success with a minor exception; the flow of tears is so profuse at meal time that the veteran looks like he is crying whenever he eats.

The VA hospital in Houston reported a successful transplanting of four parathyroid glands from a stillborn baby to a thirty-six year old veteran. The veteran's glands were removed eight years ago because of cancer. He had survived on synthetic hormones but was becoming sensitive to the extracts.

Volunteer health insurance programs paid $2,900,000 to help cover the cost of hospital, surgical, and medical care last year. The Health Insurance Council estimates that as of May 1, 1957, 118,000,000 persons were protected under

this type of insurance. This is over seventy per cent of the total U.S. civilian population. 103,-000,000 are covered for surgical expenses, 67,-000,000 for regular medical expenses, and 10,-000,000 are insured against major (catastropic) medical expenses.

Hospital care insurance continues to be the most popular form of health insurance. 66,259,-000 persons held policies of this type with insurance companies; 53,162,000 were enrolled by Blue Cross-Blue Shield; and 4,654,000 were protected through miscellaneous plans.

The Upjohn company announces that Orinase is now available to the medical profession as a prescription product. This is the beginning of a new era for the diabetic. Approximately 18,-000 of the nations 1,600,000 diabetics used the drug under experimental conditions with no serious adverse side effects.

There is good news for the chronic or habitual nail biter. A natural colored coating is applied to a clean, short or stubby nail. The plastic material dries quickly but is too hard to bite off. The coating is said to cure the nail biting habit in 30 days and is sold in drug stores as 'Stop Bite!'

A new oral alcoholic solution of theophylline (Elixophyllin) was announced recently by Sherman Laboratory. This product produces a high blood theophylline level within 15 minutes which persists up to four hours. Reports have appeared on its usage in the treatment of bronchial asthma and angina pectoris. In some cases instantaneous relief of dyspnea, wheezing and retrosternal tightness occurred.

Chas. Pfizer and Co. has changed the name of sigmamycin to signemycin-V. The change was made to eliminate any possibility of confusion with products bearing similar names but having entirely different indications. This combination of antibiotics is reported to be very effective against staphylococci.

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Treatment of pruritus ani

Itch is sometimes not bad for a patient. That may seem rather heartless but we know that if you cure pruritus ani abruptly, the patient may proceed to acquire some other condition, perhaps one that is worse or harder to handle. Just dwelling on that thought for a moment, we might say then that using hydrocortisone ointment, which is to me almost a miracle drug in this location, is perhaps not the best kind of treatment. Perhaps we should get the patient only slightly or mostly better but not completely well, allowing him to have some symptom which may be an emotional outlet. I am not a psychiatrist but I believe we all have to use psychiatric skills in the treatment of pruritus ani. *George M. Lewis, M.D. Choice of Therapy in the Treatment of Pruritus Ani. New York J. Med. May* 15, 1957.

NEWS of the STATE



BUREAU

Society News.—Dr. William J. Farley, Peru, a member of the Illinois Obstetrical and Gynecological Society, addressed the Bureau County Medical Society at St. Margaret's Hospital, Spring Valley, June 11, on "The Interpretation of the Female Pelvis."

COOK

Special Society Elections.—Dr. Ralph H. Kunstadter was recently elected president of the Chicago Pediatric Society. Other officers are Dr. Noel G. Shaw, Evanston, vice-president; Dr. Raymond F. Grissom, Oak Park, secretary; Dr. Howard Traisman, Chicago, Editor; Dr. Philip L. Aries, Chicago, treasurer. Members of the Executive Committee are Drs. Eugene McEnery, Maxwell P. Borovsky, and S. C. Henn.—Dr. Kalman Gyarfas was recently elected president of the Illinois Psychiatric Society. Other officers are Dr. Nathaniel S. Apter, vice-president; Dr. Alberto de la Torre, secretary-treasurer; Dr. Hugh T. Carmichael and Dr. V. G. Urse, councilors; Dr. John R. Adams, delegate to the District Branches of the American Psychiatric Association, and Dr. Isadore Spinka, alternate delegate, all of Chicago.

Davis Memorial Lecture.—Dr. Elmer Belt, Los Angeles, recently presented the Annual D. J. Davis Memorial Lecture on Medical History at the University of Illinois College of Medicine. His subject was "Leonardo da Vinci's Medical Observations."

Warren Furey Reelected President.—Dr. Warren W. Furey, formerly president of the Chicago Medical Society, has been reelected president of the board of the Tuberculosis Institute of Chicago and Cook County.

Promotions at Northwestern.—Dr. John A. D. Cooper, an assistant dean at Northwestern University Medical School, has been promoted to a full professorship of biochemistry, and Dr. F. John Lewis has been named professor of surgery. Dr. Lewis came to Northwestern last year from the University of Minnesota Medical School where he was associate professor of surgery.

Memorial to Dr. Gibson.—The Chicago Pediatric Society will devote its meeting, November 19, to a memorial to Dr. Stanley Gibson, noted pediatrician who died recently. Dr. Gibson, at the time of his death, had been professor emeritus in pediatrics at Northwestern University Medical School and an active member of the staff of Children's Memorial Hospital. Dr. Helen B. Taussig, Baltimore, renowned for her work on the surgical repair of the heart of the "so-called" blue baby, will deliver the scientific portion of the program honoring the memory of Dr. Gibson.

Pasteur Award.—Gail M. Dack, director of the Food Research Institute and professor of bacteriology at the University of Chicago, was recently presented with the 1957 Pasteur Award, which is given annually by the So-

ciety of Illinois Bacteriologists, Inc., to an outstanding bacteriologist in the midwest. Professor Dack was honored for his contributions to food microbiology, especially in regards to the etiology of bacterial food poisonings.

Twenty-Five Years' Service Observed.—Gold watches and citations were given, June 11, to two physicians for their twenty-five years' service at Michael Reese Hospital. The physicians are Drs. Albert Tannenbaum, director of cancer research, and Dr. Heinrich Necheles, head of the hospital's gastrointestinal research department. According to the Chicago Tribune, presentations were made by Grant J. Pick, Michael Reese board chairman, at ceremonies which also honored thirty-seven employees of more than twenty-five years' service, twenty-eight who have been employed by the hospital more than twenty years, and twenty-eight who have worked there more than fifteen years.

Grant for Research.—Northwestern University Medical School has received a grant of $5,000 from the Asthmatic Children's Aid of Chicago to support studies of asthma and other allergies. The grant will be used to investigate allergy to insect dusts, a newly found cause of asthma and hay fever. That insect dust is a major cause of respiratory allergy was first reported last year by Dr. Samuel Feinberg, Northwestern professor of medicine. Research will be carried on in the Northwestern allergy research laboratory by Dr. Feinberg, Dr. Alan R. Feinberg, instructor in medicine, and Jacob J. Pruzansky, Ph.D., assistant professor of biochemistry. The Asthmatic Children's Aid was organized several years ago to assist asthmatic children in Chicago. The 1,500-member group of women now also supports research and clinical programs.

Personal.—Dr. Thaddeus J. Jasinski, Cicero, has been elected president of the National Medical and Dental Association of America, and Dr. Gervaise Pallasch, Chicago, vice president. The organization is composed of physicians and dentists of Polish descent.—Dr. Clifford J. Barborka was recently chosen president of the American Gastroscopic Society.—Dr. Franklin C. McLean, emeritus professor of physiology, University of Chicago, has been awarded the honorary degree of doctor of medicine by the University of Lund, Lund, Sweden. As part of the award, which was presented in ceremonies in the Cathedral of Lund, Dr. McLean received a ring, a diploma, a top hat and a salute of two cannon shots.

Bernard Michela Joins Rehabilitation Institute Staff.—Dr. Bernard J. Michela, formerly instructor and consultant in physical medicine and rehabilitation at Georgetown University Hospital and St. Elizabeth's Hospital, Washington, D.C., has been named assistant medical director and chief of physical medicine at the Rehabilitation Institute of Chicago.

The Rehabilitation Institute, located at 401 East Ohio Street, commenced operations in March, 1954, for the treatment and guidance of people disabled by injury or disease with the aim of restoring them to a useful life. It is a non-profit organization supported by fees from patients and by contributions from industry and the public.

Dr. Levine Named Chief Pathologist.—Dr. Victor Levine, professorial lecturer in pathology at the Chicago Medical School, was recently named chief pathologist for the coroner's office by Coroner McCarron. The appointment was effective July 1.

La Rabida Affiliates With University of Chicago.—La Rabida Jackson Park Sanitarium, known for its work with children having rheumatic fever, is now an affiliate of the University of Chicago School of Medicine, according to a recent announcement. The sanitarium will continue to be used by the staff of Northwestern University Medical School, the University of Illinois College of Medicine, Chicago Medical School and the Stritch School of Medicine of Loyola University. Dr. Hugh McCulloch, former medical director at La Rabida, has been named new chief of staff of the institute which has been created within the medical department of the University of Chicago as a part of the affiliation, and Dr. Albert Dorfman has succeeded Dr. McCulloch as medical director.

Dr. Sheinin Honored.—On May 9, Dr. John J. Sheinin, president of the Chicago

Medical School, was one of several outstanding Americans who were presented with the 1957 Horatio Alger Award at a meeting in New York. This award was established several years ago by the American Schools and Colleges Association in an effort to combat a trend of thought that equal opportunity was a thing of the past. According to the Bulletin of the Chicago Medical School, Dr. Sheinin received the highest number of votes in the final selection of winners. His story, without doubt, exemplified the spirt of American tradition. Following the Russian Revolution after World War I, when he was a lad of twenty, he fled to this country. He faced hardship and danger all of the way and was nearly shot by a firing squad.

He arrived here penniless and unable to speak English. He worked as a laborer in a factory, as a helper on the sidewalks of New York, and also as a helper with a sign-painting company.

After making his way to Alabama, and with only $4.00 to his name, he sought out the University of Alabama determined to enter school. He completed arrangements for college entry and secured work with a local sign painter. Now began a period of extreme hardship and deprivation. Finally admitted to medical school, he was an outstanding student, especially in anatomy. He was a student-teacher until recommended to a teaching and research fellowship at Northwestern University.

While completing work for the degree of M.D., and Ph.D. he painted signs while studying and teaching and worked at night as a hospital extern. Yet, he received A's in all of his graduate work, the bulletin stated.

Symposium on Diabetes.—An all-day symposium on "Recent Developments in Diabetes Mellitus" (pathology, diagnosis and therapy) will be sponsored by the Chicago Diabetes Association, November 20, at the Drake Hotel, Chicago. Registration is scheduled for 8:45 a.m. and lectures will begin at 9. Physicians registering for the course will be charged an enrolment fee of $25.00, with the exception of members of the Chicago Diabetes Association, and the American Diabetes Association, who may enroll without charge.

Members of the Academy of General Practice who attend the conference may claim hour-for-hour Category II credit.

Henry T. Ricketts, M.D., Professor of Medicine, University of Chicago Clinics, will be Moderator, and the following program will be presented:

Pathology of Diabetes Mellitus in Man, Aaron Arkin, M.D.; professor of medicine, University of Illinois College of Medicine.

Metabolic Derangements in Diabetes Mellitus, Rachmiel Levine, M.D., chairman, department of medicine, Michael Reese Hospital, Chicago.

The Metabolism of I131 Labeled Insulin, Solomon A. Berson, M.D., and Rosalyn S. Yalow, M.D., chief and assistant chief, Radioisotope Service, Veterans Administration Hospital, New York.

Insulin Resistance, Arthur R. Colwell, M.D., professor of medicine and chairman, department of medicine, Northwestern University Medical School, Chicago.

Oral Hypoglycemic Agents in the Treatment of Diabetes, Alexander Marble, M.D., Joslin Clinic, professor of medicine, Harvard Medical School, Boston.

Current Concepts of the Pathogenesis of Diabetic Retinopathy, David A. Rosen, M.D., department of ophthalmology, Kingston General Hospital, Kingston, Ontario.

Diabetic Nephropathy, Robert M. Kark, M.D., professor of medicine, University of Illinois College of Medicine, Chicago.

Juvenile Diabetes, Howard S. Traisman, M.D., associate in pediatrics, Northwestern University Medical School.

LAKE

Howard Schulz Joins AMA Staff.—Howard N. Schulz, since 1946 industrial hygienist for Abbott Laboratories, has joined the staff of the Council on Industrial Health of the American Medical Association. His work will be primarily with industrial hygiene problems, but will also include assignments in many routine activities of the Council, ac-

cording to the Secretary's Letter of the AMA. Mr. Schulz will continue to serve the Lake County Medical Society as executive secretary.

Name Members of Newly Created Health Board.—A seven member committee has been appointed for the recently created Lake County Health Department. Names are: Highland Park, one year, Allan A. Wolff, Jr.; Waukegan, one year, Dr. Walter Reedy, Lake Forest, two years, Dr. E. H. Ibbotson; Antioch, two years, William C. Petty; Long Lake, three years, F. W. Lagerholm; Libertyville, three years, Dr. Earl Klaren; Barrington, three years, Mrs. John B. Mullen. The committee was named by Emmet Moroney, chairman of the board of supervisors of the health department, with which the newly appointed group will work.

ST. CLAIR

Negro Physician Honored.—Dr. Earle Williams, Lovejoy, was recently inducted into the Fifty Year Club of the Illinois State Medical Society. Presentation of the gold pin and certificate, emblematic of the honor, was made by Dr. Willard W. Fullerton, Sparta, Councilor of the Tenth District. A member of the St. Clair County Medical Society, Dr. Williams is believed to be the first Negro to receive this award, according to the Bulletin of the St. Clair County Medical Society.

WHITESIDE

Physicians and Lawyers Meet.—The Whiteside-Lee County Medical Societies and the Whiteside and Lee County Bar Societies held a joint meeting in Sterling, June 26, to witness a movie on "Medical-Legal Problems".

WINNEBAGO

Pfizer Company Host to Society.—Members of the Winnebago County Medical Society were guests of the Pfizer Company at a golf outing at the Mauh-Nah-Tee-See Country Club recently. Mr. Hi Henry, local detail man for the company, directed the affair which concluded with a cocktail party and dinner in the evening.

New Members.—Drs. Zdzislaw C. Koenig and Paul F. Wilkinson, Rockford, are new members of the Winnebago County Medical Society. Both physicians are engaged in orthopedics with offices in the Talcott Building.

SANGAMON

Physicians Honored.—Drs. George J. Mautz and A. C. Baxter, Springfield, were inducted into the Fifty Year Club of the Illinois State Medical Society at a recent meeting of the Sangamon County Medical Society. Presentation was made by Dr. Jacob E. Reisch, Springfield, Councilor of the Fifth District.

VERMILION

Personal.—Dr. Fred L. Crockett, Danville, has been voted into probationary membership in the Vermilion County Medical Society.

Society News.—Dr. James G. Miller, chief of the Mental Health Research Institute, University Hospital, University of Michigan, Ann Arbor, addressed the Vermilion County Medical Society recently on current medical research.

GENERAL

Dr. Gowen Goes to Chile.—Dr. G. Howard Gowen, who has been for many years deputy director of the Division of Hospitals and Chronic Illness for the Illinois State Department of Health, resigned to become chief of the Division of Health and Welfare in the U. S. Operations Mission in Santiago, Chile. According to the Illinois Health Messenger, during the period that Dr. Gowen has been associated with the state department of public health and largely through his efforts, the program for the control of cancer has been greatly expanded. State-aided cancer diagnostic clinics are now in operation in 29 Illinois hospitals, where more than 4,500 persons are examined annually.

For distinguished service in the control of this disease, Dr. Gowen last year received the annual award of the American Cancer Society, Illinois Division.

Also under the guidance of Dr. Gowen, a program for the prevention of rheumatic fever was initiated by the state department of public health in cooperation with the local communities. Through this service some

3,000 Illinois children are currently receiving prophylactic drugs for the prevention of recurrent attacks of his crippling disease.

Postgraduate Courses.—The Chicago Medical Society will conduct two postgraduate courses at the Knickerbocker Hotel, Chicago, in November. The first in general medicine, November 4-8, has been divided into the following sections: cardiovascular and renal, pulmonary and digestive system. The second course, November 11-15, will be devoted to obstetrics, gynecology and pediatrics. The registration for both courses will be $75.00 each. Additional information may be obtained from the Chicago Medical Society, 86 East Randolph Street, Chicago 1, Illinois.

New Grade A. Milk Law.—All fluid milk sold at retail in Illinois for human consumption, with certain exceptions, must now conform to the requirements of the Grade A milk law, which became effective July 1 in accordance with legislation enacted by the General Assembly in 1955.

Certain milk products, such as evaporated, condensed or dried milk, butter, cheese and ice cream, are exempted from the provisions of the law, unless such products are labeled as Grade A.

Also exempted are milk and milk products furnished by persons engaged primarily in agricultural production to employees working on the farms where the milk is produced. The law further exempts milk sold by the producer on the premises where the milk is produced, provided that animals producing such milk are free from tuberculosis and brucellosis and that such milk is free from sediment, according to the Illinois Health Messenger.

Prior to the enactment of the 1955 legislation, the Grade A milk program in Illinois had been on an entirely voluntary basis so far as milk producers were concerned.

The Grade A milk law, passed in 1939, made the State Department of Public Health responsible for setting up standards for the production of Grade A milk and milk products. Milk produced in accordance with these standards became eligible for labeling, sale and distribution to Illinois consumers as Grade A milk.

Recent Appointees to Mental Board.—Governor Stratton recently named six medical educators as members of the governing board of the state psychiatric training and research authority established under a 1955 law. The authority began functioning July 1 as a unit of the state welfare department "to train psychiatric personnel, and to advance knowledge thru research in the causes and treatment of mental illness or mental deficiency," it is reported. Those appointed to terms expiring January 1, 1959 are Drs. William E. Adams, professor of surgery, University of Chicago; Francis J. Gerty, head of the department of psychiatry, University of Illinois College of Medicine; Roy E. Grinker, director of psychosomatic and psychiatric research and training, Michael Reese Hospital; William H. Haines, Cook County Criminal Court behavior clinic director; Jules H. Masserman, professor of psychiatry, Northwestern University Medical School; Peter J. Talso, assistant chairman of medicine, Stritch School of Medicine of Loyola Universtiy, and Noble H. Kelley, Ph.D., psychology department chairman, Southern Illinois University, Carbondale.

Ex-officio board members are Dr. Otto L. Bettag, state public welfare director; Dr. Frederick W. Slobe, chairman of the state board of public welfare commissioners, and Dr. Percival Bailey, director in Chicago of the Illinois State Psychopathic Institute.

DEATHS

Charles C. Barrett*, Princeton, who graduated at Rush Medical College in 1902, died May 27, aged 83.

Eleazar S. G. Barron, Chicago, who graduated at the University of San Marcos, Lima, Peru, in 1924, died June 25, aged 59. He was a professor in the Department of Medicine at the University of Chicago.

Charles R. Curtiss, retired, Joliet, who graduated at Illinois Medical College in 1900, died June 18, aged 78. He had practiced medicine in Joliet for 50 years.

Harry Bacon Fitz Jerrell, retired, Raymond, who graduated at Northwestern Uni-

*Indicates member of the Illinois State Medical Society.

versity Medical School in 1904, died in the Hillsboro Hospital, March 22, aged 86.

Stephen Decatur Hancock, Rosiclare, who graduated at St. Louis College of Physicians and Surgeons in 1908, died in the Harrisburg Medical Foundation, March 12, aged 78, of arteriosclerotic heart disease.

Bernard T. Hoffman, retired, formerly of Chicago, who graduated at the Chicago College of Medicine and Surgery in 1912, died in his home in Glendora, Calif., July 6, aged 84.

Harvey C. Houser*, Westfield, who graduated at Bennett Medical College, Chicago, in 1914, died recently, aged 70.

John Bertram Larsen*, Morris, who graduated at Rush Medical College in 1932, died March 18, aged 63, of cancer. He was a member of the staffs of the St. Joseph Hospital in Joliet and the Morris Hospital.

Reuben L. Larsen, formerly of Evanston, who graduated at Northwestern University Medical School in 1916, died in Seattle, aged 63. He was a lieutenant commander in the Navy in World War II.

Carroll Francis Leonard*, East St. Louis, who graduated at St. Louis University School of Medicine in 1931, died March 19, aged 52. He was senior instructor in internal medicine at St. Louis University School of Medicine; chairman of the St. Clair County Tuberculosis Association; associate physician, St. Mary's Group of Hospitals, and director of the East Side Public Health District.

Dana Meade Littlejohn*, Pana, who graduated at the Chicago College of Medicine and Surgery in 1914, died March 14, aged 74, of gastric ulcer and general arteriosclerosis. He was a member of the staff of the Huber Memorial Hospital.

Donald E. Maynard*, Glenview, who graduated at Northwestern University Medical School in 1922, died June 17, aged 62.

George Fenton Ritchey, Bushnell, who graduated at Washington University School of Medicine, St. Louis, in 1910, died March 8, aged 73, of coronary occlusion.

Richard E. Valentine*, Quincy, formerly of Tallula, who graduated at Louisville Medical College, Kentucky, in 1904, died June 13, aged 77.

Isidor Walter, Chicago, who graduated at St. Louis College of Physicians and Surgeons in 1909, died January 9, aged 80. For many years he was asociated with the Lincoln State Hospital.

Edward V. J. Young*, Chicago, who graduated at Illinois Medical College in 1917, died July 8, aged 72.

*Indicates member of the Illinois State Medical Society.

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BOOK REVIEWS



DIAGNOSIS AND TREATMENT OF PERIPHERAL VASCULAR DISORDERS, by David I. Abramson, M.D., F.A.C.P., Professor and Head of the Department of Physical Medicine and Rehabilitation, and Professor of Medicine, University of Illinois, College of Medicine; and Chief of Physical Medicine and Rehabilitation, University of Illinois Research and Educational Hospitals: Attending Physician Michael Reese Hospital, Mt. Sinai Hospital and Veterans Administration Hospital (Hines); Consultant in Peripheral Vascular Disorders, Regional Office, Veterans Administration, Chicago — 537 pages, 82 illustrations, copyright 1956, Hoeber-Harper, New York. $13.50.

Until recently the only hope that could be held out to those suffering from advanced structurol alterations in the main arteries in the extremities was that of amputation to control or eliminate the pain of the associated trophic disturbances. Even in early cases of arterial insufficiency, few therapeutic measures were available for use.

In this well illustrated, well written book, Dr. Abramson discusses the medical and surgical advances which have changed the outlook for these patients to a point where amputation is no longer considered to be the inevitable outcome. In this volume he attempts to make such knowledge conveniently accessible to the busy family physician by dealing with the various circulatory disorders in such a manner that pertinent information is readily available to him for clinical application Presentation of the material closely follows the line of reasoning necessary to cope successfully with the problems that arise.

The first part discusses differential diagnosis of signs and symptoms indicating existance of some abnormality of the peripheral blood vessels. Several chapters under this part describe simple diagnostic tests that can be performed at the bedside or in the office.

In part two disorders of the peripheral arterial venous and lymphatic systems are discussed as to therapeutics and diagnostics. This material is extremely readable and is complete to the point that data is included regarding conditions rarely seen in general practice.

The Author has set up criteria to aid in the separation of the patient with peripheral vascular disorder from one with a nonvascular entity associated with abnormalties in the limbs. The subject matter, therefore, will prove of value also to the Orthopedist, the Neurologist and the Dermatologist.

Also in part two are included therapeutic procedures described in sufficient detail to serve as basis for treatment without recourse to other sources. In addition to chemical formulas, proprietory names of drugs are used and their source is available in the appendix.

In the third and last part of the volume are

(*Continued on page 44*)



in allergic eczemas

Meti-Derm CREAM 0.5%
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5 mg. METICORTELONE and 5 mg. Neomycin Sulfate
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presented those anatomic, physiologic, and pharmacologic facts which pertain to and help explain the pathologic alterations underlying peripheral vascular disorders. The physiologic basis for the various chemical tests and therapeutic procedures is also included.

This book should acquaint the physician with a logical approach to his problem and should present to him in simple form a clear concept of diagnosis and treatment of the more common disease entities in this category.

G. W. C.

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ATLAS OF CLINICAL ENDOCRINOLOGY, by H. Lisser, A.B., M.D., and Roberto F. Escamilla, A.B., M.D. The C. V. Mosby Company, St. Louis, 1957. 476 pp., with 148 plates, including 3 in color. Price $18.75.

The authors are two of the most distinguished members of this specialty. This book reflects their large experience. They have also drawn on the literature for unusual cases or for clearer illustrations of some endocrine disorders. According to the authors' preface, they "offer this volume, a clinical work by and for clinicians." They also observe that "in the main — diagnosis and appropriate treatment rest upon clinical evidence." Without minimizing in any way the value of laboratory work, that is a statement with which most experienced clinicians will be in complete aggreement. The primary purpose, the authors say, "is to offer a concise and largely visual presentation of endocrine disorders in atlas format with an abbreviated text which contains all essentials for adequate diagnosis and therapy." It seems to this reviewer that they have pretty well attained this objective.

The book is divided into eleven Sections as follows:

Section I.	Pituitary Gland (Hypophysis Cerebri)
Section II.	Hypothalamus
Section III.	Thyroid Gland
Section IV.	Parathyroid Glands
Section V.	Adrenal Glands
Section VI.	Pancreatic Islets (Islets of Langerhans)
Section VII.	Testes
Section VIII.	Ovotestis
Section IX.	Ovaries
Section X.	Miscellaneous
Section XI.	Appendix

Some of these are divided into several subsections, each dealing with various phases of the disorders which the glands manifest. For example, the Section on the Pituitary Gland is divided into:

Anterior Lobe (Adenohypophis)
- Hyperpituitarism
- Hypopituitarism

Posterior Lobe

Other Syndromes
- Nonfunctioning Pituitary Tumors, With or Without Hyperpituitarism
- Adult Aneoplastic Hypopituitarism (This is a particularly fortunate description for clinicians in the Middle West where many such cases are seen)
- Frohlich's Syndrome

Section V. Adrenal Glands is divided into ten subsections or chapters, each dealing with some phase of adrenal disorders as: Cushing's Disease and Cushing's Disease, Adrenogenital Syndrome, etc., etc. Each of these disorders is well illustrated with pictures of patients in various phases of the disturbance, pictures of tumors or other findings.

One regretable fact is that the senior author did not discuss his own wide experience in the treatment of mild or incipient gigantism — a subject that sadly needs ventilating.

The bibliography, while not extensive, will undoubtedly suffice for busy clinicians in this field.

The book is well written. Its discussions are brief and to the point. Anyone interested in this field — and every practitioner of medicine should be — will find it a convenient and valuable reference work.

J. H. H.

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TREATMENT OF HEART DISEASE: A CLINICAL PHYSIOLOGIC APPROACH by Harry Gross, M.D., F.A.C.P., Attending Physician, The Montefiore Hospital; Assistant Clinical Professor of Medicine, Columbia University College of Physicians and Surgeons, and Abraham Jezer, M.D. Attending Physician, The Montefiore Hospital; Assistant Clinical Professor of Medicine, Columbia Uni-

(*Continued on page* 46)



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Dramatic response to DIAMOX in resistant cases of petit mal has been described.[1] Administered daily to 78 patients responding poorly to standard medication, DIAMOX achieved these results: 34 patients were free of seizures within 2 days, 33 others experienced no seizures during the first month, and 11 had only one or two attacks a month. Only two patients failed to respond to therapy.

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Supplied: Scored tablets of 250 mg.

1. Golla, F. and Hodge, R. S.: Letters to the Editor, Lancet 1:304 (Feb. 25) 1956.

2. Bergstrom, W. H.; Carzoli, R. F.; Lombroso, C.; Davidson, D. T.; and Wallace, W. M.: A.M.A. Am. J. Dis. Child. 84:771 (Dec.) 1952.

Lederle LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

*Reg. U. S. Pat. Off.

versity College of Physicians and Surgeons. The W. B. Saunders Company, Philadelphia, London, 1956 Pp 549, with 91 Illustrations, Price $13.00

This a presentation of therapy in heart disease based upon sound physiologic principles. The book is divided into seven parts and an appendix. The first part consists of cardiac physiology; following sections deal with degenerative diseases, inflamation of the heart or the results of infection, co-genital anomalies, effects of pregnancy and surgery on the heart, effects of metabolic disturbances and vitamin deficiencies on heart disease, and finally, the adjustment to emotional disturbances and the problem of rehabilitation. The appendix contains a wealth of material on low sodium, low cholesterol, low caloric diets, menus, recipes, and Sodium and Potassium tables.

In a very readable style the authors discuss recent thorough revisions in the treatment of Congenital heart disease, including descriptions of the latest techniques in localization of cardiac lesions.

Effects of anesthetic agents on cardiac rythm and myocardial functions are presented and consideration is given to the danger of surgery in cardiac patients. A clinical approach to the management of the patient who requires operation is discussed.

The physiologic changes caused by pregnancy and their effect on the various cardiac conditions, together with current medical and surgical therapy, are presented in great detail.

In keeping with present trends, a very interesting discussion on the role of emotional problems in the production of cardiac symptoms may be found in the chapter on "Psychosomatic Aspects of Heart Disease." Means of preventing and treating such problems are explored. The text closes with a chapter on "Rehabilitation" which deals with the maintenance of the cardiac patients place in his family and in the community.

It is the stated intention of the authors to reach the general physician who, imbued with the physiologic point of view, may more readily understand the symptoms and clinical course of his patients. They have well attained their goal.

G. W. C.

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BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

TEXTBOOK OF PATHOLOGY With Clinical Applications; Stanley L. Robbins, M.D., Associate Professor of Pathology, Boston University School of Medicine; Lecturer, Harvard Medical School and Tufts University School of Medicine. Pages: 1351; Illustrations: 933 figures; Publication date: May 8 1957; Price $18.00. W. B. Saunders Company, Philadelphia.

COLLECTED PAPERS OF THE MAYO CLINIC AND THE MAYO FOUNDATION. Edited by Richard M. Hewitt, M.D., John R. Miner, Sc.D., James R. Eckman, Ph.D., Katharine Smith, B.A. Carl M. Gambill, M.D., Florence S. Schmidt, B.S.E., George G. Stilwell, M.D., Guy Whitehead, Ph.D., Edition: Volume XLVIII; Published June, 1957. Pages 778; Illustrated. Price $12.50. W. B. Saunders Company, Philadelphia.

A MANUAL OF PHARMACOLOGY and its Applications to Therapeutics and Toxicology. By: Torald Sollman, M.D., Professor Emeritus of Pharmacology and Materia Medica School of Medicine, Western Reserve University, Cleveland. Eighth Edition; 1535 pages; Price $20.00. W. B. Saunders Company, Philadelphia.

THE SPECIALTIES IN GENERAL PRACTICE. Editors: Russell L. Cecil, M.D., Professor of Clinical Medicine, Emeritus, Cornell University Medical College, New York City; and Howard F. Conn, M.D., Fellow, Department of Physiology, Baylor University College of Medicine and the Blue Bird Clinic, Methodist Hospital, Houston, Texas. Second Edition; 780 pages. Illustrated. Price $16.00. W. B. Saunders Company, Philadelphia.

MEDICAL PHYSIOLOGY. Edited by Philip Bard, Professor of Physiology, School of Medicine; The Johns Hopkins University. Tenth Edition. 438 Illustrations, five in color. The C. V. Mosby Company, St. Louis. Price $14.00.

PSYCHOSOMATIC MEDICINE, A Clinical Study of Psychophysiologic Reactions. By Edward Weiss, M.D., Professor of Clinical Medicine, Temple University Medical Center, Philadelphia, and O. Spurgeon English, M.D., Professor and Head of Department of Psychiatry, Temple University Medical Center, Philadelphia. Third Edition; 557 pages; Illustrated. Price $10.50. W. B. Saunders Company, Philadelphia.

AN ATLAS OF CARDIAC SURGERY. Prepared by Jorge A. Rodriguez, M.D., Assistant Professor of Surgical Anatomy and Research Associate, Department

(*Continued on page* 52)



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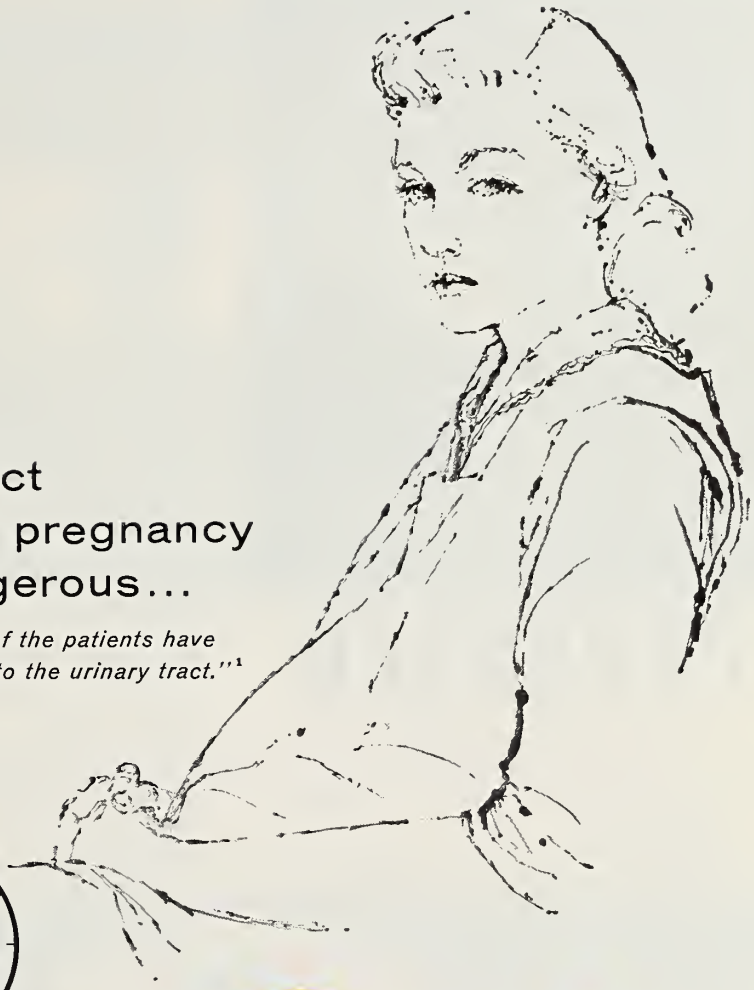
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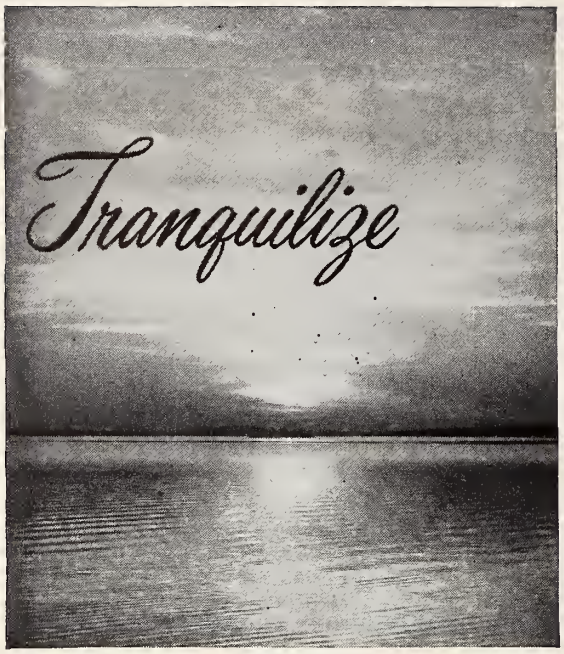
SUPPLIED: Tablets, 50 and 100 mg. Oral Suspension (25 mg. per 5 cc. tsp.).

REFERENCES: 1. Rives, H. F.: Texas J. M. **52**:224, 1956. 2. Diggs, E. S.; Prevost, E. C., and Valderas, J. G.: Am. J. Obst. **71**:399, 1956. 3. MacLeod, P. F., et al.: Internat. Rec. Med. **169**:561, 1956.

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Fatigue and efficiency

A concept of skill fatigue that has been developed from experiments in England on the effects of protracted operation on skilled performance may provide a clearer understanding of the ways in which fatigue affects the efficiency of the driver. One early effort involves changes in the timing of the reactions. Gross mistakes may appear at later stages but at first the right response is made but at the wrong time. As fatigue increases, the field to which the driver is responding as a whole loses its integrated quality and he reacts to individual aspects of it. Certain stimuli predominate whereas others may be ignored and important responses omitted. For example, after halting for a stop sign at an intersection where there are no traffic lights, the tired driver may wait for a green light to signal the time to proceed or, intent on a clear roadway on the other side of an intersection, he may derive no meaning from the headlights he sees coming from the side. As skill fatigue develops, standards of performance deteriorate, and the operator thinks he is doing as well as previously whereas actually he is driving less skillfully and no longer recognizes or appreciates his errors. Loss of insight into the seriousness of the situations encountered is a characteristic of skill fatigue that has the most important implications for safety. *Ross A. McFarland, Ph.D. and Roland C. Moore, Ph.D. Human Factors in Highway Safety. New England J. Med. Apr.* 25, 1957.

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Experiences with epileptics

A hundred experiences were studied in about 2,000 epileptics. The most interesting point that emerges is that the range of emotions experienced was narrow and confined to the primary emotions of fear (61), depression (21), pleasure (9), and unpleasure (9). Anger and rage were observed in some other cases. In all except one case the emotion was associated with other ictal sensations (hallucinations, and somatic or visceral feelings). Cognitive activity was rarely part of the aura and, though elaborate experiences might be described, they had the diffuse quality of dreamy states, as Hughlings Jackson so aptly called them long ago. *Editorial. Emotions and Epilepsy. Brit. M. J. Feb. 9, 1957.*

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Results of rehabilitation

The preliminary results of a pilot project at the New York State Rehabilitation Hospital to provide comprehensive rehabilitation services for physically handicapped welfare recipients have been analyzed in respect to changes in ability to ambulate, capability for self-care, vocational potential, and in living arrangements. Although the patients admitted under this project had been considered to be permanently and completely disabled, the results from rehabilitation were encouraging. Seventy-three per cent of the first 100 patients discharged were considered to have improved as a result of treatment, and in over 50 per cent the improvement was moderate or marked. It is reasonable to conclude that there exists an unknown but sizable number of welfare recipients, now totally disabled, who could benefit substantially from intensive rehabilitation if the opportunity were extended to them. *Herman E. Hilleboe, M.D. et al. A Pilot Program for the Rehabilitation of Disabled Welfare Recipients. New York J. Med. May* 15, 1957.

The serving of food

The symbolic meanings of food have clear implications for people who select or serve food to strangers. We accept food best from those we consider our friends or allies. We most enjoy eating with people who are close and emotionally desirable to us—our parents, good friends, children. "No one cooks like Mama," they say; an unspoken parallel is that food tastes particularly good when also shared with Mama. In the greater world of experience it still holds true that we are most accepting of new food, new table companions, or new cooks when the people involved seem congenial and acceptable to us. Perhaps this is a reason why the family doctor has traditionally got more acceptance of prescribed food changes that the specialist home economist and dietitian. The physician has the advantage of an established friendly relation with his patient, whereas the nutrition specialist has to try to obtain the patient's acceptance even while she gives the dietary advice. *Harriett Bruce Moore. The Meaning of Food. Am. J. Clin. Nut. Jan.-Feb.* 1957.

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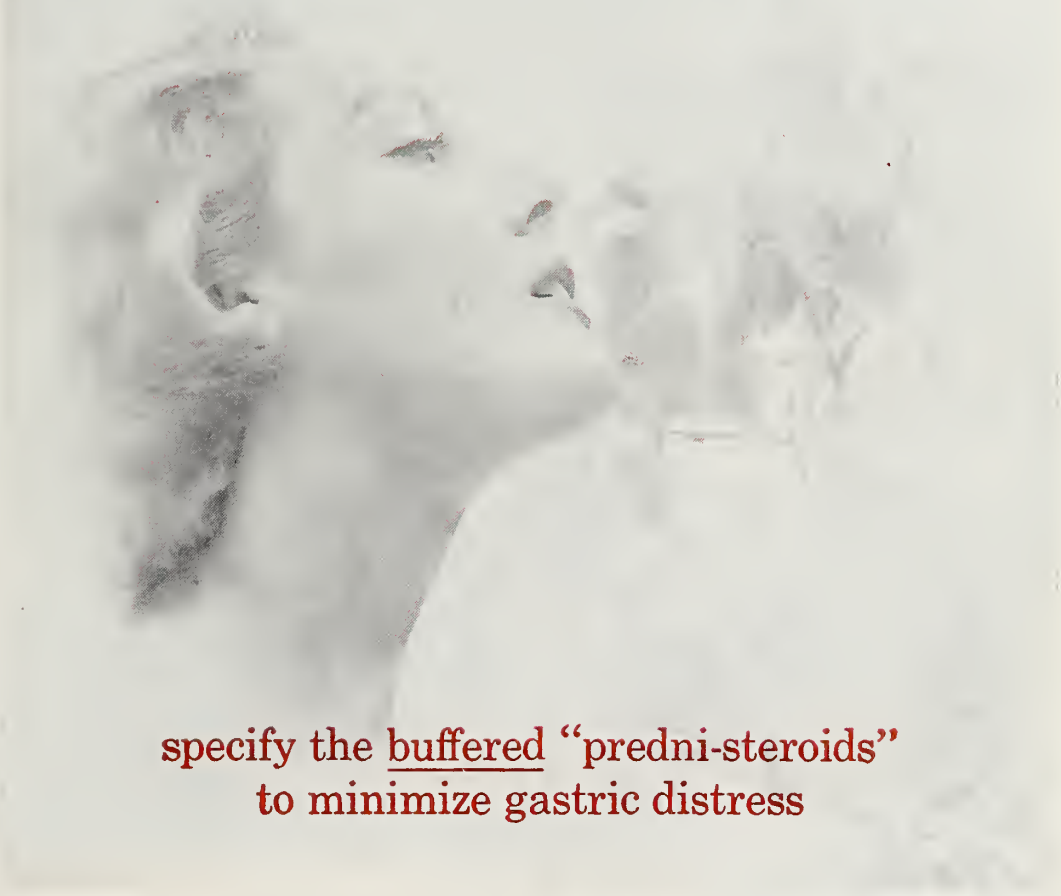
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Diabetes insipidus

The characteristics of the diabetes insipidus resulting from hypophysectomy have been discussed. It is suggested that the severity of the diabetes insipidus depends upon the degree of destruction of the hypothalamic-hypophyseal action. Considerable destruction of the supraoptic-para nervosa system may lead to diabetes insipidus which is mild enough to escape clinical diagnosis. There is no evidence that the hormones of the anterior pituitary are necessary for the production of diabetes insipidus. Polyuria is but a rough clinical guide in assessing diabetes insipidus, and reliance should be placed on urine concentrations. *M.B. Lipsett, M.D. and O.H. Pearson, M.D. Further Studies of Diabetes Insipidus Following Hypophysectomy in Man. J. Lab. & Clin. Med. Feb.* 1957.



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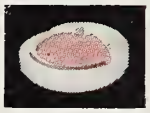
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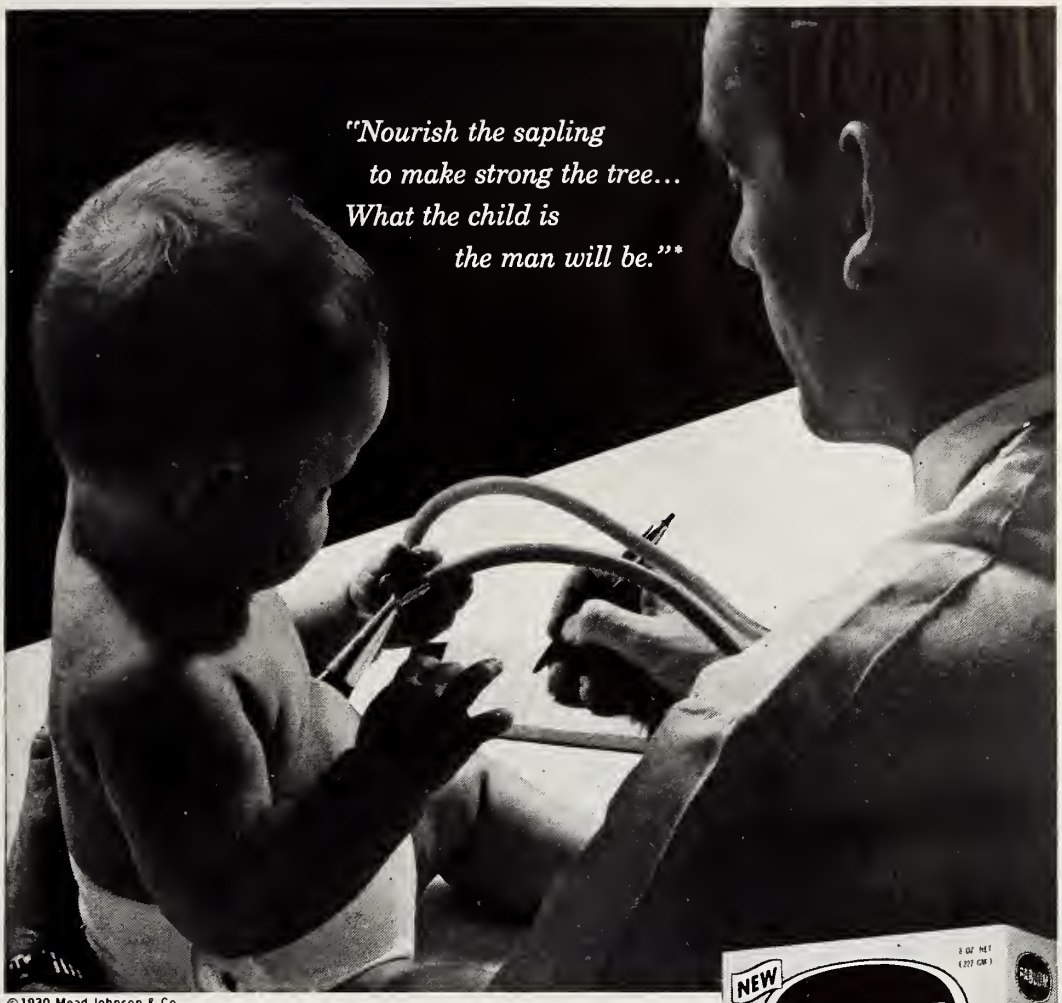
Post pneumonic collapse

Mechanisms responsible for delayed resolution and partial collapse of the right upper lobe after bacterial pneumonia are unknown, but a number of possible explanations may be suggested. Since most of the patients had severe chronic alcoholism, with a reversal of the albumin-globulin ratio, and in almost a third there was leucopenia rather than leucocytosis, a deficiency in the body's defense mechanism may somehow be implicated. Animal studies indicating that some such deficiency may be important have been reported but these results cannot be related directly to the patients in question. A second possibility is that peculiarities of the vascular supply and lymphatic drainage of the right upper lobe predispose the patient with chronic alcoholism to abnormal healing. In this connection it is of interest that Mitchell, in reviewing cases of pulmonary tuberculosis treated in the era before chemotherapy, noted that the response was less favorable when the disease involved the right rather than the left upper lobe. A third possibility is that pleural involvement caused by extensive pneumonitis will lead to retraction of the horizontal and oblique fissures, causing atelectasis and impaired drainage of the bronchioles. No direct evidence is available to support any of these hypotheses. *William M. M. Kirby, M.D. et al. Differentiation of Right Upper Lobe Pneumonia from Bronchogenic Carcinoma. New England J. Med. May 2, 1957.*

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One and the same

Parkinsonism and paralysis agitans are regarded by some experts as the same disease whereas others feel that parkinsonism is postencephalitic and characterized by a somewhat different sequence of events than is idiopathic paralysis agitans. The postencephalitic disorder may follow shortly after encephalitis or appear years later. The idiopathic disorder may occur during the process of aging. In postencephalitic parkinsonism, rigidity is the earliest and outstanding clinical feature with tremor appearing subsequently. The reverse is true in the idiopathic parkinsonism that occurs as a rule later in life and has a more insidious onset. *Claude E. Forkner, M.D. Encephalitis and Parkinsonism (Practitioners' Conference). New York Med. Sept. 20, 1956.*



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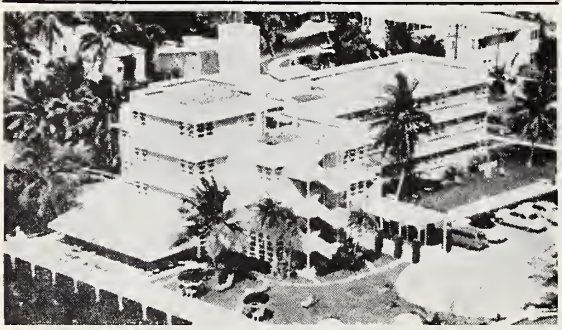
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—*Roger Babson*

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The Month in Washington

Washington, D. C.—If dangerous epidemics of Asian flu break out in the country this fall and winter, the medical profession will have its hands full. But the doctors won't be taken by surprise, nor will they lack specific information on proper treatment.

While the attacks in the U. S. were still sporadic and the death rate low—three fatalities in the first 11,000 reported cases—a number of major, nationwide efforts were under way to combat the disease in the months when influenza rates generally are the highest.

1. Acting in co-ordination with U.S. Public Health service, the American Medical Association was pressing forward with its campaign to insure that all physicians are informed on how to deal with the disease.

2. In line with recommendations of the AMA committee, a number of state medical societies by mid-August had laid out complete emergency plans, ready to be put in operation if needed.

3. U. S. Public Health Service epidemic intelligence experts were scanning the country for outbreaks that might be Asian influenza, and other PHS officers were investigating acute respiratory diseases. PHS also set up machinery to keep the medical and health professions informed on nationwide developments in the influenza picture.

4. Advising Surgeon General Burney was a special committee, which included representatives from AMA, American Academy of Pediatrics, American Academy of General Practice and the Association of State and Territorial Health Officers.

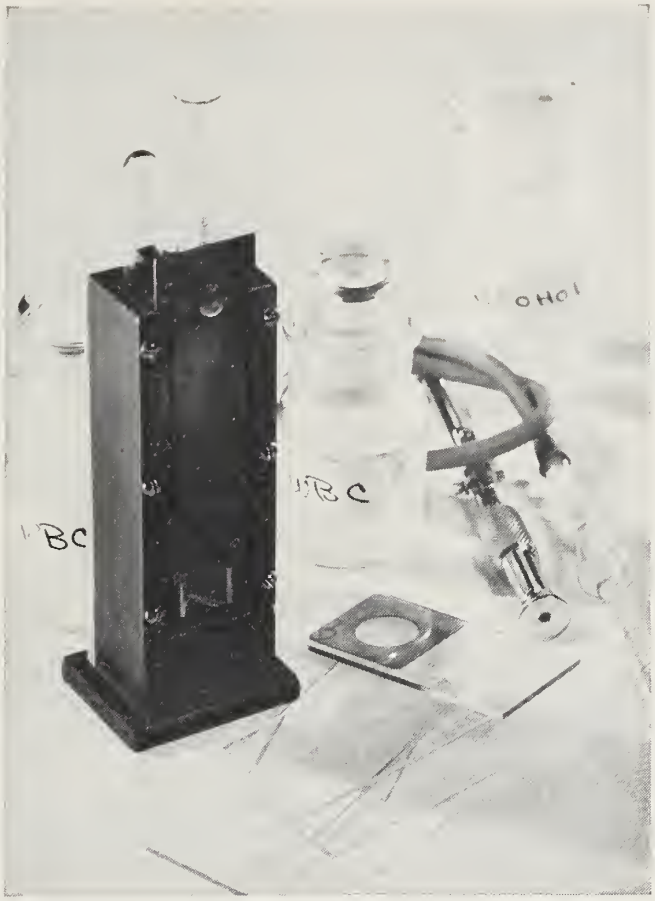
5. Manufacturers of the vaccine, by running their plants on two or three shifts and seven days a week, were hoping to have produced 60,000,000 cc. by February 1.

There was, of course, the possibility that with Congress in session through most of the summer a vast federal program would be set up, with the U. S. purchasing and allocating the vaccine. It was heartening to the medical profession that this possibility was pretty well eliminated in the early stages when the Department of Health, Education, and Welfare announced the following as official policy:

> "The Public Health Service, in co-operation with the medical profession, will stimulate and promote a nationwide voluntary program of vaccination against the prevalent strain of influenza. It will not, however request federal funds for the purchase or administration of vaccine—except for its own legal beneficiaries. The State and Territorial health officers and the American Medical Association have jointly assured the Surgeon General that community resources, both public and private, will be mobilized to provide vaccinations for persons who are unable to pay for such protection."

This policy was reaffirmed later by the White House, when the President asked for half a million dollars to finance the additional work for Public Health Service. The White House statement said flatly that it did not plan to have the federal government buy vaccine.

(Continued on page 32)



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WASHINGTON (Continued)

The AMA's Board of Trustees selected as members of the special committee the same physicians who make up the Civil Defense Committee, with Dr. Harold C. Lueth as chairman. In addition to the work of this committee, special articles are being published in the AMA, mass circulation media are being used to bring information on Asian influenza to the lay public and the AMA Council on Drugs is investigating and reporting to physicians on the use of antibiotics in treatment of the disease.

NOTES

To wind up a long investigation of the safety of chemical additives to foods, a House committee called in a panel of scientists for two days of discussion. In general they concluded: Be careful about any mandatory federal controls.

Another hearing on weight-reducing preparations sold over-the-counter in drug stores heard a parade of witnesses, all of whom had about the same opinion: In themselves, the pills virtually are useless in inducing loss of weight, but their other effects range from harmless to dangerous.

Veterans Administration is increasing fees to physicians under the hometown care program, with the new schedules varying by states and areas. During this fiscal year VA will pay out $8 million under this program.

A former AMA president, Dr. Elmer Hess, now heads two government advisory committees, the Health Resources Advisory Committee to Office of Defense Mobilization and the Medical Advisory Committee to Selective Service, membership of which is the same. He succeeds Dr. Howard Rusk.

Secretary Folsom is considering appointing a committee of outsiders to investigate and evaluate progress on medical research by the federal government.

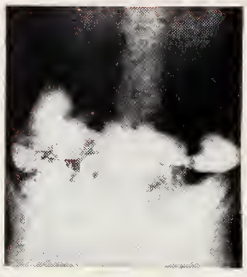
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The
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Medical Journal



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SEPTEMBER, 1957
VOL. 112. NO. 3

Terminal Care

William F. Mengert, M.D., Chicago

"THERE is a new way of dying today. It is the slow passage via modern medicine. If you are very ill modern medicine can save you. If you are going to die it can prevent you from so doing for a very long time. We cannot inquire from the dead what they have felt about this deterrent. As they fight for spiritual release and are constantly dragged back by modern medicine to try again, does their agony augment?"

These words were written by a woman who watched her husband die slowly, and were published anonymously in the ATLANTIC MONTHLY of January, 1957, in an article entitled "A Way of Dying." The words, and indeed the article, expressed so vividly my own thoughts and convictions, that I decided to make it the theme of the surgical oration.

Much of medicine is scientific. We know about the sodium, the potassium, the calcium ion, and milliequivalents. The laboratory has removed most of the guesswork from problems of fluid balance and of pre-and postoperative care at a time when the conscious, basic personality of the human being is more or less in abeyance. On the other hand, we must not carry this line of reasoning to its ultimate conclusion, ignore the individual, and consider the medical or surgical problem only in the light of applied science. Since we deal with people and not mechanical devices, we must be practitioners of the *art* of medicine as well as of its science. There is no implication in the foregoing that either the art or the science is unimportant or should be ignored. The proper blending of both makes a wonderful physician who is beloved and sought by all.

Any intelligent mind within a few years can learn the facts presented by the scientific side of medicine. On the contrary, art is long and human understanding and humility are acquired only after a long time and sometimes not at all. Thus, the young physician tends to be impatient of restrictions imposed by considerations of personality and of the dignity of man, especially when the laboratory findings so clearly indicate a logical although divergent course of procedure.

As a department chief with many years of intimate dealing with successive generations of interns and residents, I may perhaps be permitted one or two generalizations. Chief among these is unwillingness of the young physician to aeknowledge defeat in the war against disease. In medical school he received excellent training in the science of healing. Undoubtedly he witnessed surgical attack on each cavity and al-

From the Department of Obstetrics and Gynecology, College of Medicine, University of Illinois.

The Oration in Surgery, presented at the 117th Annual Meeting, Illinois State Medical Society, Chicago, May 11, 1957.

most every organ of the human body. He is aware of the dramatic possibilities of surgery but may not recognize its limitations. On the medical side he is aware of the conquest of diabetes, pneumonia, syphilis, and now poliomyelitis.

He projects to the future and argues that if a disease does not respond to known medicines, other drugs will soon be synthesized in the laboratory. Thousands of investigators in thousands of laboratories are diligently at work, pushing back the frontiers of knowlegde. Truly, we are in the golden age of medical miracles. Is it any wonder the young doctor believes that since the unknown, or the dangerous of yesterday, is understood or standard procedure of today, he may as well do something in a desperate or poorly identified situation, even though what he does may seem a bit esoteric? The young physician has been taught, and has come to believe in the invincibility of the healing powers of modern medicine and surgery. These teachings and beliefs do not encourage the development of humility, without which I believe no man can become a first rate physician.

Of course the young doctor knows that some diseases, like cancer, often result in fatality. On the other hand, emphasis in medical school undoubtedly was placed on the slogan, "Cancer is curable." Moreover, active teaching hospitals cannot devote many beds to chronic or terminal disease, thus automatically limiting opportunity to observe and practice terminal care. Unless he happened to spend a disproportionate amount of time in a tumor clinic with an excellent follow-up, death from malignant disease made little impression upon him. Therefore, he is incredulous and suffers some emotional stress the first time he meets the problem of inevitability of approaching death, in a young patient in apparently good health.

An unusually poignant illustration of this was occasioned by a 29 year old, attractive mother of three, and their sole support. She ignored the vaginal spotting beginning nearly five months before. At the time of admission she was in a good state of nutrition but had an inoperable far-advanced cancer of the cervix with massive extension to the right lateral pelvic wall. Statistically her chances of remaining alive for five years were less than 1 in 20. To look at this girl, so much needed by her family, and to realize that in all likelihood, she would not be here a few years from now, made even the most cynical of us want to do something to try to prevent the inevitable.

Therefore, it was not at all strange when the young staff doctors immediately raised the possibility of exenteration as a primary procedure. Most certainly, this operation would be done in such a case in many properly equipped institutions. I have performed it on occasion and believe it has a place among our present weapons against cancer. On the other hand, I believe it should be undertaken only after sober consideration of possible benefit, as opposed to immediate danger and the emotional adjustments involved. Furthermore, I have never performed this operation without putting the decision squarely in the hands of the patient after an unemotional and objective attempt to acquaint her with *all* of the facts and relative values pertinent to her situation. Whether removal of this young woman's rectum, urethra, vagina, urinary bladder, lower portion of the ureters, uterus, tubes and ovaries, and all of the pelvic cellular tissues and peritoneum would improve her chances of living was dubious. Because the cancer was firmly attached to the bony wall of the right side of the pelvis when she was first examined, I did not think so. Would the operation, even if it did not cure her, have brightened the closing days of her life? I did not believe so. Undoubtedly, there are many who would insist that we condemned this girl without a fair trial. This is scarcely a justifiable charge, since we did not abandon her but treated her vigorously with irradiation.

Personally, I believe in shooting the works when there is a fighting chance, and by so doing we do not increase the patient's misery and suffering. When there is no chance, I cannot condone doing something just to be going through the motions in order to kid ourselves and the patient's relatives that everything possible is being done. The physician who operates for this reason either does not possess or does not exercise human understanding and decent regard for the personality of the individual.

Prolongation of life, merely for the sake of a brief postponement of death, does not appeal to me. Sometimes it is difficult to know when

further treatment becomes useless. On the other hand, there are many times when we do know and can predict the outcome if either of two alternative courses is selected. Typical of this situation is ureteral obstruction in terminal carcinoma of the cervix. Uremia is a common cause of death with cervical carcinoma. Moreover, it represents a gradual fading and dimming of consciousness, and to me would seem to be an easy and painless way to die. Nevertheless, there are those who would perform cutaneous ureterostomy or pyelostomy on such patients. This might prolong life by six months and certainly would restore the patient to consciousness and awareness of her surroundings. But, what does she pay for these six months? At least the terminal two or three weeks will be associated with great pain and any or all of the disagreeable symptoms of late cervical cancer. I would not wish this for a loved one if the alternative were a relatively easy and painless death hastened perhaps a few months.

Sometimes the young physician wishes to prolong life because he can see no other way out of a seemingly impossible situation. Typical of this was a postmenopausal woman with carcinoma of the corporeal endometrium. At the time of operation the carcinoma had already broken through the uterus and produced a generalized abdominal carcinomatosis. There were many parietal and visceral implants and a great many adhesions between loops of bowel. Nothing was done except biopsy, the abdomen was closed, and she went home in due course of time. Months later the inevitable occurred and she returned with mild symptoms of obstruction. A tube was inserted, the patient became comfortable, but proper management of fluid and electrolyte balances became an increasingly difficult problem. Despite the fact that separation of loops of intestine from each other would have been technically difficult at the first operation and that the patient was virtually moribund, the residents almost unanimously demanded some type of intestional operative procedure. I refused, but said if they could persuade someone else to operate on her, they could do so. They did, but the patient died before the operation was done. It was demonstrated at autopsy that bowel operation would not have been technically feasible. Considering the situation at the first operation, this could have been foreseen and I am certain the residents knew it. They were, however, motivated to do something because philosophically they could not bring themselves to accept an impasse—namely, the patient could neither live with the tube nor without it.

Another example of refusal to accept the inevitable appeared among some detailed case reports recently available for study. The patient, 36 years old, was found to have a large malignant multilocular cyst so adherent to the parietes it was difficult to deliver from the abdomen, and was ruptured in doing so. There was extensive infiltration of the pelvis, particularly on the left side and about the ureter. As much tumor as possible was removed and total hysterectomy and bilateral salpingo—oophorectomy performed. There also were implants in the omentum, which was removed in its entirety. Then the patient received a full course of X-ray therapy. Six months later a cystic mass developed in the epigastrium. Localized paracentesis was performed several times with removal of one to two liters of fluid each time. Soon, she developed pleural metastases and was given localized, palliative X-ray. Nitrogen mustard was instilled into the right pleural cavity. Ten months later she developed symptoms of lower bowel obstruction and pulmonary metastases and a resection of the terminal ileum and cecum and an ileocolostomy were done. She went steadily downhill and died three months later, 19 months after the first operation.

Since the doctor was a specialist, we must assume he knew the patient was hopelessly incurable at the time of the initial operation because of the pelvic and ureteral infiltration, the adherence of the mass to the parietes, and the omental metastases. Nevertheless he performed an unnecessarily extensive operation and then made the poor woman's 19 months of remaining life miserable with traumatic and debilitating procedures. Perhaps he prolonged her life although I doubt it. If he did, whatever time he borrowed for her was not a comfortable time. Personally, I would feel his efforts would have been more profitably directed at making the closing months emotionally satisfying and at the relief of pain when it developed.

As I read the history of this poor woman,

my mind reverted to the wife referred to in the opening paragraph. Her husband was operated on, did not do well, developed some complication necessitating re-operation, became comatose, and then slowly expired. After too many weary hours of death vigil at the hospital during which many unnecessary efforts were made to keep her husband alive she was told "he's rallied." Her reply was, "How horrible." A few hours later he died. I too, feel, "How horrible," especially for the relatives, at the futile and unnecessary gestures so frequently made to prolong life.

On the facade of the Union Station in Washington, D. C. is carved in granite, the admonition, "Speed the parting quest." I do not quote this as a plea for euthanasia. It is a plea to the physician to refrain from unnecessary heroics. When confronted with a rational and sentient patient, about to embark upon the final phase of his terminal illness, the physician should ask himself the question, "If I were the patient, what would I want done to me?"

When the situation develops to the point where further efforts at maintenance of life become futile gestures, it would seem that the principal duties of the physician are to insure good nursing care and alleviate pain. Sometimes, death is a long time coming. Then I think the physician has another duty—namely, to help the patient and the relatives understand and cope with the situation. Some years ago, Montefiore Hospital in New York City instituted a program of discharging chronic, and terminal patients from the hospital, but providing excellent medical and nursing care at home. All of the facilities of the hospital were invoked whenever necessary.

Soon, it developed that much more than medical and nursing problems were involved. Chiefly, these problems centered around two important necessities: First, the patient had to be loved and wanted in the home. Second, the patient had to be given something useful to do, no matter how insignificant it was. The necessity of making him feel he was contributing something to the family life was integral to his emotional adjustment and to his successful care. Unless he was wanted, and felt he was helping in some way, the plan was defeated by the rising emotional tensions.

Both the minister and the doctor can help to make terminal care in the home successful. Since the doctor is the only one familiar with the minutiae of handling such situations and competent to advise on how much the patient can do, this duty therefore lies with him. Not only must the physician keep up his regular visits but he must also encourage the family to spend time with the patient.

In the July, 1956, issue of the British journal, *MEDICAL WORLD,* Dr. T. N. Rudd in an article entitled "The Family Doctor at the Death Bed" says, "However little we may be able to do, we cannot be relieved of our duty to visit. The importance of regular visits cannot be overstressed. It is not easy to visit helpless patients who have insight into the gravity of the illness but it is a fundamental routine which the physician should not omit on the grounds that he can do no more and that the nurses have the treatment well in hand."

I would like to quote at some length from "Medico-Moral Problems" by Gerald Kelly, S. J., concerning ordinary and extraordinary means of preserving life. "Ordinary means of preserving life are all medicines, treatments, and operations, which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain, or other inconvenience. Extraordinary means of preserving life include all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience or which, if used, would not offer a reasonable hope of benefit." Obviously the physician should employ ordinary means of preserving life. He is not obligated to employ extraordinary means. Quoting again from the same reference. "It is not contrary to the common good for a doctor to admit that a patient is incurable and to cease trying to effect a cure."

These philosophic matters are becoming of increasing concern to the public as evidenced by the number of articles appearing in various lay magazines. One of the most moving appeared in *LOOK* for March 19, 1957, and was condensed from the book "Death of a Man" by Lael Tucker Wertenbaker. Her husband, about whom the book is written, himself wrote, "Ever since I can remember, it had seemed to

me that to be deceived about the nature or progress of a serious illness or even to suspect deceit would go far toward destroying whatever fortitude one could summon to face one's trials." Mrs. Wertenbaker continued this thought, "It was a principal with him, a moral and principled man, that he had a right to die as he wished to, when he chose, if possible." The husband also wrote, "The problem with death is to recognize the point at which you can die with all your faculties and take a healthy look at the world and the people as you go out. Let them get you in bed, drug you, or cut you and you become sick and afraid. If you wait too long, you may be reduced to something less than a man."

The problem of terminal care inevitably is inseparably intertwined with the problem of what to tell the patient. After Wertenbaker underwent exploratory celiotomy and liver metastases were found, the following verbal interchange occurred,

"M.D. Now, what shall we tell Wert?

"Wife. Tell him the truth.

"M.D. You can't. You can't take hope away from a human being.

"Wife. Is there any hope?

"M.D. No.

"Wife. I cannot lie to this man. That would take his dignity away from him. He would rather have dignity than hope."

Referring again to the British journal, *MEDICAL WORLD,* Dr. Rudd says, "Too often relatives and doctors increase their own difficulties by maintaining a conspiracy of silence regarding the hopeless prognosis and the nearness of the end. Here, every situation must be judged on its merits. Generally speaking, the patient is more willing to be told than are the relatives that he should know. If, in answer to direct questions, lies are repeatedly told, the patient will either be denied knowledge of his condition which he has a right to know, or he will draw his own conclusions, and lose confidence in his attendants in the process. Undoubtedly, in almost every case, management becomes greatly simplified once the patient knows the truth and faces it. Occasionally, the dying patient grows so enormously in mental stature that he dominates the situation, and gives out strength rather than having to receive it."

Gain in emotional stature by a patient faced with death is wonderfully exemplified by a recent article in the July, 1956, issue of *FARM JOURNAL AND COUNTRY GENTLEMAN,* titled, "My Last Wonderful Days." It was written by the wife of a Dean at Iowa State College. "In a few weeks—or maybe a few days —I shall die. I shall leave my husband, my two teen-age girls, and my blue-eyed Richard, who is only 12. Every relentless tick of the clock measures off what remains of my life. Yet I am a happy woman!" She not only was able to face death with equanimity, but also found the strength to be able to prepare her entire family emotionally for her coming departure. She said, "I am determined to keep these last weeks as normal as possible for my family. Why, when I have spent years creating a happy home for them, should I give up now during these last weeks when they need the assurance of normaley more than at any other time in their whole lives?"

This is only one of a number of articles appearing recently in the lay press. Once again, I should like to comment that these philosophical matters are of considerable concern to the public and we, their physicians, should exhibit a proper understanding of their importance.

In closing, I cannot refrain from quoting excerpts from an editorial entitled "Pen-knife Surgery" appearing in the March, 1957, issue of the *ILLINOIS MEDICAL JOURNAL,* despite the fact that many of you undoubtedly read it. The editorial comments on a recent medical article. It seems the victim (a physician) collapsed on the steps of the hospital and was rushed to the emergency room. No heart sounds were heard. His chest was opened between the fourth and fifth ribs and his heart massaged. Ultimately he made an uneventful recovery. The author of the article believes this is the first reported case performed outside the operating room and suggests that lay teams be trained to take over when a patient dies from an acute heart attack. He thinks a two day course should suffice to acquaint them with technics. Reports of cardiac massage outside the operating room have appeared since the one mentioned above. A western surgeon attending a party collapsed

in the living room of his host. Two internists present opened the doctor's chest with a pen knife, after they were unable to hear heart sounds, and massaged his heart. The surgeon was revived only to succumb two days later of a second occlusion.

Doctor Hiram T. Langston a thoracic surgeon, recognizes the emergency when it occurs in the operating room, but is leery about training nonmedical personnel to wield a pen-knife. He says, "I cringe, in fact, at the appalling prospects of lay people (firemen, policemen, or golf caddies) equipped with do-it-yourself kits for cardiac arrest being willing to 'save the life' of any who may fall by the wayside. These tired and fainting people just might not be dead." If I be the one to fall and am seemingly dead, please stretch me out, loosen my clothing, and fan me. Should I be truly dead, 'tis just as well. But should I not be dead, my recovery will not have been hindered. I for one am quite convinced that should I be otherwise qualified, those Pearly Gates will swing out to admit me just as easily without a hastily done incision into my chest as with one."

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Medicine and management

I have been amazed at discovering that in many organizations with well supported medical departments, communication between the doctors and the personnel officers is almost entirely written and often is little more than the forwarding of check lists. The information which the personnel worker needs is subtle and full of delicate shadings and can be imparted only through face to face give and take in which many questions are asked on both sides in order to clear up overlooked misunderstandings. This takes time and many industrial physicians feel that this is a very scare commodity. I firmly believe, however, that if the only way to obtain enough time for developing easy understanding between the two departments is to lengthen the time between periodic health examinations, such an arrangement would better serve the interests both of the employees and of the firm. In those organizations I have visited in which there was easy informal access between the members of the two departments, necessary information appeared to flow readily and the medical department seemed to be increasingly in a position to make its rightful contribution to policy decisions. Where communication was almost entirely written, either the medical department was in but not of the organization or the doctors were complaining that the personnel department was putting pressure on them to violate ethical principles, and the personnel people were complaining that the doctors were obstinately and unreasonably standing on the letter of the law. *Temple Burling, M.D. Medical Ethics Versus Needs of Personnel Officers. Indust. Med. June* 1957.

Oliguria and Anuria

VINCENT J. O'CONOR, M.D., CHICAGO

Anuria usually appears after a period of oliguria which has existed for a few hours or several days. Except for patients who are already undergoing hospitalization, or who have had surgical proeedure, the majority of these patients are seen by the general praetitioner of medieine, or by those limiting their activity to internal medicine. If the renal function reactivates, as it often does on expeetant treatment, everyone is happy and the ineident is dismissed as one of minor importance. It should be emphasized that it is a common experienee to find a diagnosis of "anuria" being made when, actually the patient's bladder is filled with urine; the kidneys are functioning but the patient has no diseomfort and no desire to void. Naturally, the real eondition is made elear by catheterization of the bladder and may often be obvious where physieal examination outlines the overdistended bladder.

Except in patients where anuria develops during the course of urologie investigation or treatment, the urologist may not be ealled in eonsultation for several days after the laek of urinary exeretion is appreciated by the attending physician. Anuria, when it arises, may beeome the problem of the medical man or the surgeon, but eventually should inelude the urologist as well.

To the inexperienced, the oeeurrenee of oliguria and anuria in an otherwise apparently healthy subject may seem baffling and eonfusing. This should rarely be so if one takes into aeeount our present knowledge of the subjeet. Classifieation of the causes of anuria resolves itself into three principle groups:—prerenal, renal, and postrenal. The latter may inelude so-ealled reflex anuria. The anuria of the newborn—the arenal type—needs no diseussion. So-called reflex renorenal type of anuria is largely applicable to the eessation of function of both kidneys when only one of the ureters is obstrueted.

Let us emphasize that in true anuria there is no urine in the bladder.

PRERENAL CAUSES

Factors operating upon renal function before the blood reaches the kidney inelude abnormally lowered blood pressure, thrombosis of the renal vessels, hepatic disease, neurogenic reflex as after cystoseopy or other instrumentation, thyroid deficieney, dehydration by vomiting with urinary sepsis, diarrhea, shoek, or excessive perspiration. Fear, in my experienee, has eaused prerenal anuria without evidenee of shock on a number of oeeasions.

The presence of vascular eollapse assoeiated with sudden bacteremia is beeoming of mueh more frequent oeeurrenee in postoperative eare. This may be due to the indiseriminate and often prolonged use of antibioties. The condition may not be deteeted beeause the usual manifestations of shoek are absent or obseured by a warm skin, a bounding, rapid pulse, and fever. Only the deteetion of markedly lowered blood pressure—severe hypotension—may alert one to a situation that is often fatal if uneorreeted. We have seen this eondition on a number of occasions in the past few years where the elinical pieture immediately suggested a pulmonary embolism, a sudden eoronary thrombosis with myocardial infarction, or some other type of vaseular eollapse.

Oliguria, anuria, and azotemia result in these patients beeause of renal insuffieieney. Unfortunately, a large majority of these patients will die regardless of treatment. In any patient with fever, and a disease of or reeent operation on the urinary or gastrointestinal tracts, one should eonstantly be on the lookout for the possible presence of bacteremia due to gram-negative organisms. Patients who develop watery stools and severe diarrhea naturally eall attention to the possibility of the pseudomembranous en-

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terocolitis which usually is found with this condition. It has been our experience that a number of these patients have gone into vascular collapse with dyspnea and pulmonary findings who had little or no presenting evidence of a pseudomembranous enterocolitis. About 10 per cent have diabetes mellitus and it is well to consider this when vascular collapse follows a urological or an abdominal procedure associated with anuria.

RENAL CAUSES

These are directly operative upon the kidney itself and include degenerative and inflammatory diseases that are bilateral in nature. Poisoning, such as bismuth, bichloride of mercury, or carbon tetrachloride; shock; extreme suppuration, usually associated with bacteremia; reflex mechanisms, as previously stated; and severe allergic reactions of an overwhelming histamine type. Renal anuria for a time was largely caused by blockage of the renal tubules by sulfanilamide crystals, although at present, we rarely see this complication due to improvement in the acetylization of this drug. We now see renal anuria most commonly due to hemoglobin crystals in transfusion reactions or by myoglobin and hemoglobin substances in the renal tubules associated with the crush syndrome or extensive burns. These conditions may be associated with marked tubular degeneration in the kidney and often are spoken of as "lower nephron nephrosis syndrome."

POSTRENAL CAUSES

Postrenal causes of oliguria and anuria usually are those which interfere with the drainage of the urine from both kidneys or in the only kidney, when it is solitary. The most common cause of anuria is bilateral renal or ureteral calculi. This may be especially misleading in patients with nonopaque urate calculi or in individuals who form calcium carbonate stones on prolonged alkaline therapy. Each year we see a certain number of individuals who develop oliguria and often complete anuria from bilateral ureteral pressure due to tumor metastases in the retroperitoneal spaces. The most common of these occur in carcinoma of the cervix or body of the uterus. We have observed this condition in several instances where drop metastases occurred from clear celled carcinoma of the kidney. Bilateral ureteral injury or ligation following pelvic or abdominal surgery must be considered a form of postrenal anuria.

It may seem academic to emphasize again the fact that the diagnosis of anuria is made only when no urine is entering the bladder. I have been called in consultation on a number of instances where the patient's bladder was filled with urine and he was being treated for anuria. Either no attempt was made to catheterize the bladder because the patient had no desire to void or the catheterization had been unsuccessful, the catheter never entering the bladder, giving rise to the decision that there was no urine in the bladder because none had been obtained by the unsuccessful procedure.

The treatment of anuria, therefore, demands, first, prompt catheterization of the bladder; secondly, if no urine is present in the bladder, ureteral catheterization must be done immediately to identify or to relieve the obstructing factors if they are present. If both catheters pass readily to each renal pelvis and no urine is obtained from either, renal function has ceased and the diagnosis is definitely established. Ureteral catheterization is, in essence, both a diagnostic and a therapeutic procedure. In the case of prerenal anuria, it is certainly permissible to combat the lowered blood pressure, shock, or other complications by circulatory replacement of whole blood, plasma, or isotonic glucose-saline solution. The selection of intravenous fluid will depend upon the condition of the patient and whether there has been previous vomiting, urinary sepsis, diarrhea, or excessive perspiration. If anuria persists, it is not reasonable to continue this treatment alone longer than 48 hours without subjecting the patient to ureteral catheterization.

It is our habit in patients with anuria to maintain fluid balance, i. e. have the fluid intake equal the estimated fluid loss by skin, lungs, bowel, or vomiting. For an average adult, this will be from 1,000 to 1,200 cc. per day. More than this may throw an unnecessary strain upon the patient, leading to pulmonary edema and anasarca. The place for a patient in whom the diagnosis of anuria has been definitely established is the hospital where complete laboratory studies can be utilized from day to day in the application of treatment. For instance, prolonged vomiting, hyperventilation, or excessive

ingestion of alkali may bring about a condition of alkalosis characterized by a rise in the CO_2 combining power of the blood. As a result of this condition, the patient may be apathetic and exhibit signs of tetany. On the other hand, prolonged diarrhea, impaired ability of the kidneys to form ammonia, excessive ingestion of acid with impaired renal function may cause acidosis which will be characterized by a lowered CO_2 combining power. Hyperpnea may be present if acidosis becomes severe.

It should be especially noted that depletion of water alone is not commonly seen in the patient except in conjunction with depletion of salt. Prolonged vomiting, nasal suction, diarrhea, and excessive sweating usually are forerunners of this condition. Severe diuresis following oliguria or anuria or adrenal insufficiency may cause salt depletion. In a patient with salt depletion, one must not try to correct the patient's dehydration by the oral administration of water or the intravenous administration of glucose. As a result of dilution by ingested water and loss of salt, the extracellular fluid becomes hypotonic and water is excreted to maintain isotonicity. Hemoconcentration occurs and leads to increased viscosity and reduced volume of the blood. Hypotension ensues and may be followed by circulatory collapse. These patients complain of lassitude, headache and dizziness but are not thirsty, as a rule. Anorexia, stupor, and shock result.

Laboratory findings show reduced urine chlorides, low chloride and sodium findings in the plasma, azotemia, and a high hematocrit reading. Atony of the stomach, spasm of the pylorus, and acute gastric dilatation may result. It should be especially emphasized that one should never give any great amount of saline intravenously to a patient unless it is definitely needed, because it is easy to kill the uremic or oliguric patient with it. The decision as to what type of fluid to give, in a case of anuria will lie between the intelligent use of intravenous physiologic saline, 5 per cent glucose, or one-sixth molar sodium R-lactate solution, depending upon the individual case. The patient must lose water equal to about 5 per cent of his body weight before dehydration is clinically evident. Edema is not usually apparent until fluid equal to 10 per cent of the body weight is retained.

In watching a patient who is anuric, especially before or after surgical procedures, the daily weight is important. We feel that a daily weight gain which exceeds two per cent in a patient who is otherwise well hydrated but who is not eating well means retention of water and salt, and both water and salt should be stopped until the cause of weight gain is found. An overall maxim with us is that mild dehydration is always to be preferred to overhydration, since it is much less dangerous systemically. This rule certainly applies to all oliguric or anuric patients. In the anuric patient who has had a transfusion reaction or where we are dealing with a case of the crush syndrome and hemoglobinuric anuria, or hemoglobinuric anuria due to severe burn, where the laboratory tests so indicated, we have employed 2.5 per cent sodium sulfate intravenously, given very slowly and in the dosage of 15 cc. per kilogram of body weight. This treatment should never be given unless the upper urinary tract drainage is unimpeded.

If uretheral catheterization is inadequate to establish free renal drainage in cases of anuria, individual instances may demand the use of nephrostomy, ureterostomy, or other surgical procedures. It seems trite to say that the final surgical indications are those relative to definitive surgery to correct obstructive factors which is not performed until it is quite definite that the acute crisis is past and the condition of the patient warrants the procedure. We have recently observed several cases of oliguria and anuria of four to five days' duration which have recovered on conservative treatment and where the only etiological factor seemed to be exposure to carbon tetrachloride. During the same interval, we have had instances of bilateral calculi and bilateral ureteral obstruction due to the causes already mentioned. In metallic renal poisoning, we have not found renal decapsulation to be of particular value, although a few patients have recovered following this procedure. We cannot decide in these instances as to whether these patients might have opened up from a renal function point of view without the decapsulation. Sweating in these patients, as a rule, is contraindicated; it only weakens the patient and does nothing toward curing the fundamental condition.

The transfusion of whole blood is an important and lifesaving procedure but it has become the most carelessly abused procedure in medical and surgical care. The one possible exception to this statement is the ill-advised use of the antibiotics. Naturally, the blood of every patient who is to undergo a urological or surgical procedure should be carefully typed and cross-matched and the proper amount of suitable whole blood should be available if needed. This situation poses no problem in the large metropolitan hospital with its own generous blood bank, but in the smaller outlying hospital such anticipatory provisions may not be on hand. The more common complications of blood transfusion are renal and hepatic damage, leading to oliguria and anuria, so-called lower nephron nephrosis, and hepatitis.

I often wonder if the attending physician realizes that every time he gives whole blood to a patient there is a risk that the above complications—one or both—may develop. Does he know that the mortality from blood transfusions approximates that of surgery for appendicitis in the average metropolitan center? If he does know this, surely he will not be guilty of giving blood for its so-called tonic effect when the blood count is normal, or of giving blood in anticipation of possible blood loss during a surgical procedure which may be expected to be accompanied by only minimal bleeding. Neither will he give blood as insurance to the maintenance of blood pressure when there has been no appreciable blood loss during the surgical procedure. It may seem redundant to state that needed blood transfusion is one of our greatest aids in the care of the surgical patient but needless blood transfusion certainly is to to be avoided and condemned.

In recent years, attempts have been made to extract the toxic metabolities in the circulation in desperate cases of anuria. The methods that have been employed are gastrointestinal lavage, peritoneal irrigation, or the use of the artifical kidney, when available. The artifical kidney can selectively remove metabolites and electrolytes from the body in from four to eight hours. Correction of the acid base balance will be necessary in most instances in accompanying this procedure. When obstruction to the outflow of urine has been eliminated, ordinarily renal function may be expected to resume not later than six to nine days, and if life can be preserved this long, most kidneys will revive and resume function. For this reason, an artifical kidney should be available in most centers to care for this occasional patient. Careful electrolytic studies must be made so that therapy may be properly applied. It is obvious that these artificial kidney centers need to be rather few but that their facilities be available to surrounding communities. For these reasons, all doctors should co-operate with the existing artificial kidney units to apply this modality to patients who have a chance for reversal of the anuric state.

In urology, one of the more common causes of oliguria and anuria which has been recognized in recent years, is that of hemolysis accompanying various transurethral procedures. During the course of transurethral resection of the prostate gland, the venous plexus which surrounds the capsule of the gland is often cut into and offers a ready avenue for the introduction of irrigating fluid into the vascular system. Experiments have shown that as much as 1,000 to 1,500 cc. of fluid may be forced into the vascular system during a prostatic resection. It is established that the use of sterile distilled water for irrigating purposes may cause hemolysis, either within the bladder or the venous system, and as a result, renal changes of a toxic and obstructive nature may bring about oliguria, anuria, and in rare instances even death. For this reason, we use 1.1 per cent glycine solution in all transurethral procedures. Four per cent glucose solution and other isotonic fluids have been used by others.

CONCLUSIONS

Anuria is a state which may arise from a number of sources. We must distinguish the etiology as to whether it is prerenal, renal, postrenal, or reflex. We might also consider the classification from the treatment point of view as being medical, urological, and surgical. In every form of anuria, each of these methods can and must be used, depending upon the condition of the individual patient. Intelligent treatment rests upon co-operation between physician, urologist, surgeon, and laboratory technician. Fewer patients would succumb to anuria if an intelligent regimem and regard for the condition is undertaken.

Soluble Hydrocortisone and Prednisolone in Ophthalmology

Warren W. Kreft, M.D., Des Plaines

In the past decade, ophthalmology has made great strides in therapeutics. Occupying a prominent position in this advance are the various steroid preparations beginning with cortisone and more recently, prednisolone.

Past experience has shown that these suspensions were not ideal in that they had to be shaken before use. In some cases after 48 hours usage, the drops burned so severely that they had to be discontinued. In most instances this was due to admitted insufficient agitation of the suspension before use. There have been complaints of a granular foreign body sensation with their instillation and patients also have noted the collection of white material at the inner canthus. The white suspensions are easily identifiable and thus may lead to unsupervised use when they may be contraindicated. The purpose of this paper is to show that these new solutions, soon available, are effective in conditions which have been shown to be amenable to steroid therapy.

Numerous papers have already appeared on the chemistry, indications, and contraindications of these steroids.[1-8] Suffice it to say that hydrocortisone and prednisolone are synthetic preparations which differ from cortisone by the possession of a hydroxyl group in the 11 position, rather than a carbonyl group. Prednisolone differs from hydrocortisone by the possession of an additional double bond in the ring conjugated to the ketone.

Systemically prednisolone has been found to exert an anti-inflammatory action up to five times[4-6] that of hydrocortisone, with a marked decrease in side effects and toxic reactions. Several investigators have found that prednisolone is more effective than hydrocortisone topically[5,8].

However, this is difficult to evaluate precisely. The only possible manner in which it could be demonstrated would be to treat a bilateral case with two different preparations. The difficulty of such an undertaking is self-evident.

Little difference can be detected between the effectiveness of ointments and of solutions. Ointments, however, are more difficult for the patients to administer and are less likely therefore, to be effective.[1] Drops, can be administered easily by the patient with a minimum of effort, discomfort, and disability. The consensus of laboratory and clinical experience indicates that treatment of anterior segment disease usually requires only local application.[9] Moreover with the introduction of prednisolone and its low side effects and toxicity on oral administration, it is felt that subconjunctival injection of steroids will be eliminated.

The two solutions used in this series consist of hydrocortisone (Optef*) and prednisolone .2% in the alcohol form. These solutions are colorless, sterile, buffered, and iso-tonic. They have a pH of 6.5 and a surface tension of 40 dynes/squares centimeters. One-half per cent chlorbutanol has been added as a preservative and sterilizing agent. These solutions are stable at room temperatures for periods of six months or more.

I have used the diluent solution on 50 patients with no subjective complaints of stinging or irritation. Over 150 patients have been treated with these preparations with only occasional complaints of mild stinging. In no case have the drops been discontinued due to discomfort. The patients in this series used the drops, initially, every hour during the daytime and the treatment varied from one week up to

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Presented before the Chicago Ophthalmological Society, March 18, 1957.

*Solutions of hydrocortisone (Optef), and prednisolone for this study were supplied by the Department of Clinical Investigation, The Upjohn Company, Kalamazoo, Michigan.

eight months. A good result is classified as one in which there was relief of symptoms in 24 hours, and no symptoms in 7 days.

Results Obtained With Soluble Hydrocortisone and Prednisolone

	Hydrocortisone		Prednisolone	
	GOOD	POOR	GOOD	POOR
Allergic Conjunctivitis	31	3	34	2
Allergic Dermato-conjunctivitis	12	2	14	1
Vernal Conjunctivitis	4	1	3	1
Pingueculitis	3	0	4	0
Phlyctenular K. Conjunctivitis	3	0	2	0
Diffuse Episclertis	4	1	3	1
Traumatic and Post-operative Iritis	5	0	7	0
Nongranulomatous Iritis	2	0	3	0

The above table consists of eight of the most common conditions which respond to steroid therapy. Other conditions as herpes zoster, marginal ulcer, superficial punctate keratitis, and recurrent corneal erosions, also responded well to these solutions. However, they were in insufficient quantities to be significant.

Allergic conjunctivitis and dermatoconjunctivitis responded well to either solution. One case of allergic conjunctivitis which did not respond to hydrocortisone cleared with the prednisolone solution. As these cases are prone to recur, patients were given the solutions to use whenever this occurred. It was felt that the effectivity of the solutions was almost equal.

Vernal conjunctivitis, symptomatically responds very well but, as Hogan[1] found, relapse was invariable necessitating periodic therapy. Both solutions reduced the hyperemia and discharge but the papillae persisted. It was also noted that unless therapy was continuous the papillae seemed to increase in size. One case which did not respond to prednisolone was relieved with hydrocortisone.

Pingueculitis and phlyctenular keratoconjunctivitis responded to either solution equally well.

Diffuse episcleritis responded to either solution slowly. In some cases 3-4 weeks of therapy was required. One case cleared with the prednisolone solution, recurred later, and cleared with the hydrocortisone solution.

Traumatic and postoperative iritis seemed to clear rapidly with either of the two solutions. Topical atropine and hot wet packs also were used in these cases.

Nongranulomatous iritis cleared well with either solution in conjunction with atropine drops and hot wet packs. The recovery time was variable and in some cases, took 4-6 weeks for recovery.

The solutions also were used on cases which are known not to respond to steroid therapy including granulomatous iridocyclitis, chronic follicular conjunctivitis, seborrheic and staphylococcic blepharoconjunctivitis, Reiter's disease, and nodular episcleritis. In none of these was a good effect obtained. There were no cases of dendritic ulcer following use of either solution. However, it could very well occur with their indiscriminate use. I am unable to detect a clear-cut difference in the effectivity of these solutions. This may be due to the fact that as solutions they provide uniform and higher effective concentration of available steroid. Perhaps with time we may be able to more closely differentiate their individual indications.

SUMMARY

Soluble hydrocortisone and prednisolone have been found to be an excellent addition to the clinician's armamentarium in the therapy of conditions amenable to steroid therapy.

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The Renal Control of Acid-Base Balance

Malcolm Milne, M.D., Director, Renal Unit, Hammersmith Hospital, London

Doctor Norman B. Roberg, Associate Professor of Medicine: It is my very great pleasure to introduce Doctor Malcolm Milne, Director of the Renal Unit, Hammersmith Hospital, London. He will present to us today some of the newer aspects of renal physiology in regard to the control of acid-base balance.

Doctor Milne: Thank you, Doctor Roberg. I would like to present today material that is recorded in the recent literature regarding the role of the kidney in the control of acid-base balance. Since the maintenance of normal body pH is such as closely guarded constant, and since deviations from normal produce such marked symptoms, the topic is of obvious importance. Homeostasis of pH in the body is normally achieved via three mechanisms:

(1) The physio-chemical effects of the buffer systems in the body fluids both extra—and intracellular.

(2) The effects produced by variation in respiratory ventilation in the lungs, and

(3) The effects produced on the electrolyte composition and urine formation by the kidney.

In the third mechanism, the chief load presented to the kidney for biological work is the elimination from the body of excess non-volatile anions. Their presence in urine is the chief cause of its usual acidity. They consist chiefly inorganic phosphate (resulting from phospholipid, nucleic acid, and protein degradation) and inorganic sulphate (from mucopolysaccharide and cysteine degradation) and are presented to the kidney to the extent of 60 meq. per day in normal states. This amount is well within the excretory capacity of the normal kidney, but frequently above the capacity of the kidney in disease. The glomerular filtrate formed directly from the profusing plasma has a normal pH of 7.4 and a normal bicarbonate content of 27. meq. per liter. Bladder urine normally is acidic (pH down to 4.4) with little or no bicarbonate content. Obviously during the passage of the glomerular filtrate through the renal tubule, bicarbonate has been removed and acidity enhanced. The mechanism for this action is as follows: (1) the renal tubular cells of both the distal and proximal convoluted tubules produce H^+ and $HCO-_3$ via carbonic acid from CO_2 and H_2O catalyzed by the enzyme carbonic anhydrase; (2) the H^+ so formed is exchanged for Na^+ of the glomerular filtrate resulting in reabsorption of Na^+ and acidification of the glomerular filtrate; (3) the H_2CO_3 formed from $HCO—_3$ by the acidification of the glomerular filtrate decomposes to CO_2 and H_2O. The CO_2 being freely diffusable is largely reabsorbed, (4) the renal tubule cells in addition utilize H^+ produced by the carbonic anhydrase reaction for the synthesis of NH_4^+ from NH_3, the latter chiefly formed from blood glutamine by means of the enzyme glutaminase. The NH_4^+ so formed is in turn exchanged for Na^+ in the tubular lumen. As a consequence of these mechanisms, the acidity and HCO_3 content of the urine are directly determined by the intracellular acidity of the renal tubular cell.

Let us examine the operation of these mecha-

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RENAL FUNCTION IN DISEASE STATES

	Serum HCO_3^-	H^+Exchenge	Urine pH
1. $NeHCO_3$ loading	↗	N	Alkeline
2. NH_4Cl loeding	↙	N	Acidic
3. Hyperventiletion	↙	↙	Alkaline
4. Respiretory ecidosis	↗	↗	Acidic
5. KCl loading	↙	↙	Alkaline
6. KCl depletion	↗	↗	Acidic
7. Acetazolamide therepy	↙	↙	Alkeline
8. Ne_2SO_4 loading in the normal	N	N	Weekly Acidic
9. Ne_2SO_4 loeding during inc reesed sodium reebsorption	N	↗	Strongly Acidic

nisms in various disease states with the aid of the prepared table. First let us examine the effects of loading the body with $NaHCO_3$, a basic salt. This raises the serum HCO_3 load presented to the renal tubular cells by the glomerular filtrate. The tubular exchange of H^+ for Na^+ is normal or slightly reduced with the result that the glomerular filtrate is not acidified. Its HCO_3 content is maintained and the urine remains alkaline.

Loading the body with NH_4Cl, an acid salt results in a decrease of serum HCO_3 content and reduction in the load of HCO_3 presented to the renal tubular cell by the glomerular filtrate. The interior of the tubular cell is more acid, and, therefore, an increased tubular Na^+H^+ exchange occurs with the glomerular filtrate. Filtrate HCO_3 is couverted to freely diffusable CO_2 and the resultant urine is acidic with a low HCO_3 content.

In pulmonary hyperventilation, excessive amounts of CO_2 are removed reducing the serum HCO_3 and the glomerular filtrate HCO_3 load presented to the renal tubular cell, but the systemic alkalosis produced lowers the tubular synthesis of H^+ and $Na^+ - H^+$ exchange with the glomcrular filtrate resulting in an alkaline urine containing HCO_3. In this instance, the systemic and renal intracellular pH effects are more potent in determining pH and urine composition than is the filtered HCO_3 load.

In respiratory acidosis with pulmonary CO_2 retention, the serum HCO_3 and glomerular filtrate HCO_3 are increased but the systemic and renal tubular intracellular acidosis result in increased tubular synthesis of H^+ and increased $Na^+ - H^-$ exchange with the glomerular filtrate with the production of an acid urine low in HCO_3 content. When large amounts of KCl are administered to a normal person, the administered K^+ tends to assume an intracellular position while the administered Cl^- remains extracellular. As a consequence, intracellular H^+ concentration is reduced and a simultaneous intracellular alkalosis and extracellular acidosis result with reduction of serum and glomerular filtrate HCO_3. Renal tubular H^+ synthesis is reduced by the intracellular alkalosis and, in addition, the large amount of K^+ competes with the renal cell H^+ for Na^+ exchange in the glomerular filtrate. Thus, renal cell $Na^+ - H^+$ exchange is markedly reduced and an alkaline urine of high HCO_3 content is produced despite extracellular "evidence" of acidosis (decreased serum HCO_3).

By contrast, in KCl depletion states, the reduction of intracellular K^+ is compensated by the movement of both Na^+ and H^+ intraceulularly, resulting in intracellular acidosis and extracellular alkalosis as manifested by increased serum HCO_3. The intracellular acidosis of the renal tubular cell results in increased H^+ synthesis in increased $Na^+ = H^+$ exchange and because less K^+ is available to compete with H^+, in augmentation of $Na^+ = H^+$ exchange, with the consequence that an acid urine of low HCO^3 content is produced despite extracellular "evidence" of alkalosis manifested by the elevated serum HCO_3. It can thus be seen that in both K^+ deficiency and K^+ excess states, urine of paradoxical quality is produced which can be understood only in terms of events occurring within the renal tubular cell between Na^+ H^+ and K^+ ions.

The administration of acetazolamide (Diamox®) blocks the action of the enzyme carbonic-anhydrase, apparently by competitive inhibition. This results in less H^+ synthesis by the renal tubular cell, less $Na^+ - H^+$ exchange and the production of an alkaline urine with high HCO_3 content and consequent reduction of the serum HCO_3.

Finally, it is of interest to study the effects of administration of the sodium salt of a rapidly excreted anion such as $SO_4=$ (in the form of Na_2SO_4) in the normal human as contrasted to the human with excessive sodium

retention. In the normal subject, serum HCO_3 is unaffected by the neutrality of the administered salt, and as a consequence renal tubular H^+ synthesis and Na^+ exchange is normal so that an acid urine of low HCO_3 content results solely from the sulphate content of the glomerular filtrate. In contrast, in subjects with excessive sodium retention, as in all states of secondary aldosteronism, the adrenal stimulus for increased Na^+ exchange from the glomerular filtrate results in the loss of excessive amounts of H^+ and K^+ into the urine so that maximum degrees of acidification of the urine are achieved upon Na_2So_4 administration with reduction of urine pH levels to as low as 4.0, a level never achieved normally.

I would now like to elaborate my remarks on the effect of varied K^+ states on renal pH control. K^+ is considered to be an important cofactor in the function of such intracellular enzymes as ATP which provide for energy utilization. In potassium deficiency states, the minimim pH achieved by the stimulation in gastric juice production and by the kidney in acidification of the urine is markedly impaired, as is renal osmotic concentration of the urine so that a urine of fixed specific gravity and neutral pH is more likely to be produced. This can be verified by loading subjects with NH_4Cl before and after K^+ depletion and noting changes in the urine produced. When K^+ depletion is achieved after NH_4Cl is administered, the ability of the kidney to acidify and concentrate the urine is markedly decreased and this state is reversed by administration of K^+. In addition, the administration of NH_4Cl for periods of longer than three days tends to deplete the body of K^+ by causing K^+ losses from the intracellular spaces and replacement with H^+ so that in these circumstances again, renal inability to acidify and concentrate results, again reversed by K^+ adminstration. The chronic use of NH_4Cl therapeutically is thus undesirable from this standpoint. The effect of K^+ depletion on renal function is also seen in diabetic acidosis where a urine is produced that is less acidic than might be expected by the severe acidosis present systemically. In these conditions, the serum K^+ concentration is a poor index of total body K^+ content for three reasons: (1) the systemic acidosis reduces intracellular K^+ (by replacement with H^+ and Na^+) and raises extracellular K^+ to an unrepresentative level in serum; (2) the extracellular volume is contracted tending to concentrate its contained electrolytes; and (3) the oliguria usually present to a variable degree tends to promote K^+ retention which is soon reversed on fluid and insulin therapy. For these reasons, we usually suggest the early and generous use of K^+ replacement in the course of a diabetic acidosis therapy feeling that K^+ depletion is frequently present to an unexpectedly severe degree.

I would like to conclude my remarks with a discussion of the role of renal NH_4^+ production in renal control of body pH. Of the total amount of 60 meq of non-volatile anions of which the kidney must rid the body each day, only 20 meq of this is achieved by titratable acidity and pH changes and the remaining 40 meq is excreted by means of union with NH_4^+ produced by the renal tubular cell from H^+ of the carbonic anhydrase reaction and NH_3 from the action of glutaminase on blood glutamine and other $NH_3=$ joining compounds. Very little NH_3 is present in the free form in arterial blood. It is carried chiefly as glutamine from the liver to the kidneys. The liver is the chief site of urea synthesis from NH_3 in the body.

Renal NH_4^+ synthesis can be discussed in two general categories. In the first, variations in the transport of NH_3 occur. In acid urine, NH_4 is increased and in alkaline urine NH_4^+ is decreased. Similarly, in oliguria, urine NH_4^+ is decreased and in polyuria, urine NH_4^+ is increased. In the second category, variations of NH_4^+ production occur usually accompanied by concomitant changes in the concentration of glutaminase enzyme, in the kidney. For example, in chronic systemic metabolic acidosis, urine NH_4^+, and renal glutaminase concentration are all increased whereas they are decreased in metabolic alkalosis. They are similarly increased in total body K^+ depletion or under the influence of acetazolamide (Diamox), chiefly by virtue of their effect on intracellular H^+ and subsequent renal NH_4^+ synthesis and $Na^+NH_4^+$ exchange with a glomerular filtrate.

In patients with primary aldosteronism who demonstrate an alkaline urine with urinary K^+ loss and Na^+ retention and total body K^+ depletion, the chief method of non-volatile anion excretion occurs via renal NH_4^+ syn-

thesis and exchange, despite the urine alkalinity while titratable acidity production is low. When KC1 is administered to replace depleted body K^+ stores, the urinary pH falls and the partition between NH_4^+ and titratable acidity in anion union becomes approximately equal.

The ability of the kidney to synthesize NH_4^+ for Na^+ exchange is limited by the amount of glutamine transported to the kidneys in the blood (usually 400 meq. per day maximum) and the ability of the renal tubular cell to synthesize H^+ from the carbonic anhydrase reaction. This limits renal NH_4^+ production to about 300-400 me. per day maximum. A total amount of NH_4^+ and H^+ needed for non-volatile anion exchange is approximately inversely proportional to the serum HCO_3 concentration and is easily exceeded in such states as diabetic acidosis, excessive anion production in diabetic acidosis and decreased renal NH_4^+ synthesis in the uremic. Since the liver is able to detoxify 24 gms. of NH_4Cl daily to urea, free NH_3 elevation of the blood rarely results from diabetic or uremic acidosis.

By way of contrast, alkalosis is much less of a clinical problem than acidosis chiefly because of the ease of alkaline excretion in the urine through suspension of tubular exchange of Na^+ and H^+. Huge quantities of $NaHCO_3$ (up to 1000 meq. per day) can be excreted by patients with moderately reduced renal function without great change in body pH and only in terminal renal failure is ability to excrete alkali impaired, and then chiefly because of limitation of glomerular filtrate and not of limitation of tubular function.

Doctor Roberg: Thank, you, Doctor Milne, for your interesting and comprehensive discussion of the subject.

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Hyponatremia

Over the past decades edematous patients undergoing repeated treatment with mercurial diuretics have been observed to exhibit, on occasion, a rapid deterioration of circulatory and renal function. This state was found to be associated with a depressed concentration of sodium in serum, and from this association was born that enigmatic and contentious term, the low-salt syndrome. The rapid development of flame photometry quickly established hyponatremia to be a not infrequent biochemical sign in such patients wrung dry by the overenthusiastic use of diuretic measures or in patients whose edema had become obstinately refractory to conventional forms of therapy. Nor did the results of the ubiquitous, if not indiscriminate, measurement of serum sodium levels stop there. It was soon appreciated that many chronically ill patients, with and without edema, were hyponatremic and were adamant in their resistance to the endeavors of the therapist to restore the aberrant dimension to his preconceived ideas of physiological normality. Patients with normal or excess stores of sodium clearly contained water in even greater excess of at least that portion of body sodium that was in aqueous solution; and their regulatory mechanisms were subverted to the maintenance of this distorted relationship, although for the whole body the excess of sodium was greater than that of water. Thus, the etiologic significance of hyponatremia became more and more befogged, although all too clear was its prognostic significance as a hallmark of impending dissolution. *Editorial. Hyponatremia: Clinical State or Biochemical Sign? Circulation. Dec.* 1956.

Glaucoma Detection in General Practice

Edward Gallardo, M.D., La Salle

As an introduction to the subject, it might be pertinent to give a few figures in order to emphasize the importance of glaucoma as a clinical entity and in the field of social economics.

Glaucoma is the single greatest cause of blindness in the United States. According to the latest figures[1], about 43,500 persons, or 13% of all the blind in this country, lost their vision as a result of glaucoma. The incidence of undetected glaucoma has been estimated at about 2% of the population above the age of 40, or approximately 1,200,000 persons.

Hankla[2], during a survey conducted in Philadelphia in 1953, found that in the age group 35 to 44, the incidence of glaucoma was 1.5%, while in those over 65 years of age it was 3.7%. No difference was found by race or sex within the same age groups.*

Glaucoma attacks both eyes nearly always, although rarely at the same time. A lapse of from a few hours to five or more years may be observed. In a recent study by Winter[3], it was shown that in cases with acute congestive glaucoma, 62% of the attacks in the second eye occurred within five years of the first attack in the first eye.

Blindness from glaucoma is costing the United States taxpayer about $16 million annually in pensions, rehabilitation, and professional care. These figures are bound to grow, proportionally to the growth in total population, as well as the growth in the older age groups.

There are many facts and opinions regarding the etiology and classification of glaucoma. To quote from the more relevant literature only, on etiology alone, would take hours. The subject is being revised from time to time as new evidence, experimental or clinical, is published. Therefore, due to the limitation of time, and the prevalence of general practitioners in this audience, I shall limit this presentation to a brief outline of the two main categories of primary glaucoma: the acute and subacute congestive type, also called narrow or shallow angle glaucoma, present in 40 to 45% of cases, and the chronic simple noncongestive, or wide angle glaucoma, comprising about 55 to 60% of the cases.

The first type is relatively easy to diagnose in most instances and responds well to therapy. The chronic variety is more difficult to detect, and is often unpredictable to medical as well as surgical management. Both types, together with many of the secondary glaucomas due to uveitis, cataract, trauma, or tumors are characterized by one common feature which may be temporary or constant, and that is the elevation of the intraocular pressure. It follows that, in the present state of our knowledge, the measurement of this pressure becomes the first and most important step in diagnosis.

Gunderson[4], stated "there is no substitute for tonometry, and only with a tonometer can the early diagnosis be made." To this I like to add that tonometry should be included as a routine procedure in every physical examination. The tonometer is just as easy to use as the sphygmomanometer and, with proper care, just as accurate. Of course, a good number of cases of chronic simple glaucoma will escape detection by the use of tonometry alone, but many others will be diagnosed or suspected before irreversible changes take place in the optic nerve.

The diagnosis of true congestive glaucoma is difficult to miss. Onset of pain is severe and sudden, with equally sudden impairment of vision. The pupil is fixed and half dilated. The

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Read at the 117th Annual Meeting of the Illinois State Medical Society, Chicago, Ill., May 23, 1957.

**Since the first draft of this paper, Kurland and Taub (Am. J. Ophth 43:539, April 1957) found a higher rate of primary glaucoma in females, outnumbering males almost two to one in the city of Rochester, Minn.*

globe is hard and painful to palpation. The intraocular pressure is generally above 60 mm. Hg. with the Schiotz tonometer, or well above the normal line with the Berens-Tolman tonometer. In subacute cases of congestive glaucoma, however, the onset may not be as dramatic; some of the typical signs and symptoms may be obscured or absent. Finger palpation becomes unreliable as a method of testing the intraocular tension. Here, the use of the tonometer during the attack is a must for correct diagnosis, due to the fact that once the acute episode is over (sometimes a few hours), the eye may return to normal, often without the benefit of therapy, or in spite of it if treated for other inflammatory diseases, with which it may be confused. Here is where most of the mistakes are made with such conditions as iritis, keratitis and conjunctivitis. In the table of differential diagnosis, therefore, we are concerned with the symptomatology apparent in a majority of cases. There are exceptions in each disease group, where one or several of the symptoms may be slight, or exaggerated, and occasionally even absent.

The diagnosis of chronic non-congestive glaucoma, on the other hand, must be made by correlating several symptoms which are not, as a rule, present at the time of the first examination. Therefore, the history of the patient becomes all important. The following points should be included as a minimum questionnaire:

1. Blindness in the family, not due to injury or senile cataracts.
2. Frequent changes of glasses, none of which is satisfactory.
3. Inability to adjust to darkened rooms, such as theater, TV, etc.
4. Occasional blurring of vision, headaches, vertigo, nausea.
5. Rainbow rings around lights.
6. Loss of peripheral vision.

When any of the above symptoms or a combination of them is present, glaucoma should be suspected and a tonometric reading may change the doubt into a positive diagnosis. If the tension is normal, the patient should be referred to an ophthalmologist for further study, including visual fields, gonioscopy, and if necessary a provocative test which will bring the hidden ocular hypertension into a manifest level.

TECHNIQUE FOR TONOMETRY

The patient should lie flat on his back and 1 or 2 drops of 0.4% Dorsocaine® HCl or any other suitable anesthetic, instilled in each eye. After 2 or 3 minutes, allowed for the local anesthetic to take effect, the patient is reassured as to the absence of sensation in the eyes and asked to look straight up at a fixed point in the ceiling, or better yet at his own thumb held about 16 inches directly above the eyes. The lids are separated carefully, avoiding pressure on the eyeball. The footplate of the tonometer is applied to the center of the cornea and the barrel of the instrument is lowered till the needle moves and then stops at a fixed level, oscillating gently with the patient's pulse. The procedure is now repeated in the opposite eye and the tension in each is recorded and compared. One should avoid pumping the tonometer while resting on the eye because this maneuver will bring down the pressure, and occasionally produce tears in the corneal epithelium.

A difference of more than 5 mm. Hg. on the Schiotz tonometer in either eye is considered significant, even when the pressure is below 25 mm. With the simplified Berens-Tolman instrument, designed for use in general practice, the indicator line will move towards a red dot if the tension is high, but it is not calibrated to register small differences in pressure. Nevertheless, it is considered adequate for

(Glaucoma) Table of Differential Diagnosis

	Pain	Photophobia	Congestion	Secretion	Pupils	Tension: mm Hg
IRITIS (acute)	±	+++	++	0	contracted	normal or lower
KERATITIS	±	+++	+++	++	normal	normal (16 to 24)
CONJUNCTIVITIS	±	±	+++	+++	normal	normal
CONGESTIVE GLAUCOMA	+++	±	+++	0	dilated	40 or more (Schiotz) High (Berens-Tolman)

the average cases of glaucoma when used according to instructions (5).

EMERGENCY TREATMENT

A person with an attack of acute congestive glaucoma is a true emergency, with which every physician may be confronted, particularly in rural areas. Therefore, I feel justified in mentioning something about therapy. Treatment must be directed at the immediate reopening of the angle of the anterior chamber, which has been obliterated by the root of the iris pushing against the corneoscleral junction, blocking the outflow of aqueous humor. This can be attained by the use of pilocarpine 2 to 4% solution, instilled every 1 or 2 hours, combined with Diamox® 250 milligrams orally, followed within a few hours by 250 mg. of a delayed action tablet of the same drug. The pressure-lowering effect of Diamox and pilocarpine are additive, Diamox by reducing or suppressing the formation of aqueous fluid, and pilocarpine by improving the outflow through miosis. Strong analgesics and hypnotics, of course, are almost always necessary.

If the tension remains high under this management for more than 6 to 8 hours, surgery should be done without delay. Results of treatment are good in a majority of cases after the first attack. On successive attacks, it becomes progressively worse, and more complicated procedures, such as lens extraction, may be necessary in addition to iridectomy and the continued use of miotics.

The treatment of chronic simple glaucoma is often disappointing, regardless of the method used. This is due not only to our incomplete knowledge of the etiology, but also because the patient is frequently unaware of the disease until the vision is greatly reduced as a consequence of optic nerve atrophy. In some cases, nevertheless, the medical management with miotics and Diamox seems to offer more hope now than it did a few years ago, before the introduction of Diamox.

Finally, I like to emphasize the obvious, but neglected fact, that many victims of glaucoma are first seen by the general practitioner, and the detection of a fair number during the early stages could be made in his office. The extra time required would be that of a few questions pertinent to the eye included in the general history, and 3 to 5 minutes added for tonometry. Recent evidence provided by glaucoma clinics and surveys in large cities, indicate that a nation-wide screening program, if properly organized with the co-operation of men in general practice and industrial medicine, would reduce materially the incidence of undetected glaucoma, and resultant blindness.

The following steps are suggested as a tentative outline for the implementation of such a program:

1. The obligatory teaching of tonometry and ophthalmoscopy in medical schools, on the same level of proficiency as auscultation or sphygmomanometry.
2. Demonstration of tonometry to medical staff members in all hospitals by local ophthalmologists or other trained personnel.
3. Occasional showing of a technical film at hospital staff meetings, dealing with various aspects of glaucoma[6].
4. The formation in small towns of local chapters, including professional and lay persons affiliated with the respective State Society for the Prevention of Blindness.
5. The production of non-technical films on glaucoma and other blind-producing diseases for use before lay audiences.

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The Therapeutic Effectiveness of a Fungistatic Powder for Tinea Pedis

GEORGE H. SCHERR, PH.D., AND ZENO N. KORTH, M.D., OMAHA, NEBRASKA

THE use of a powder preparation as a prophylactic measure for the superficial mycoses or as an adjunct to the use of a liquid or ointment in the course of therapy has become well established in the profession. This report presents clinical support for the successful therapeutic use of a powder preparation in the treatment of tinea pedis.

In the course of treating tinea pedis with certain preparations (Scherr *et al.* 1955) a number of patients who did not respond to the various regimens were then placed on Asterol®* powder, here designated by the code # 28. Patients were directed to sprinkle the powder on and between the toes once a day in the morning after washing but immediately before putting on the socks. The preparations used initially were liquids, some in common use for the treatment of the superficial mycoses. Their specific composition is not pertinent to the results and conclusions of this study and they are designated by various code letters. The criteria for infection, course of the disease, and other aspects of the methology were those previously used and reported (Scherr *et al.* 1955).

Following the use of the various liquid preparations the course of the infection was graded as regression (R), no charge (NC), improved (I), or cured (C).

In a few instances, which are designated in the accompanying table, patients having tinea pedis were given #28 powder as the initial therapeutic preparation.

This report was compiled from treatment data for children at the St. James Orphanage in Omaha, Nebraska. Because of the close supervision given to the children, this study was very well controlled.

Table 1 records the results of this study. The mean time to cure, using Asterol powder, was 21.6, 23.5, and 32.0 days for the mild, moderate, and severe infections respectively; the per cent cured for this series was 88%, 94%, and 75% respectively. It is significant that the cure was as effective whether the powder treatment fol-

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*Hoffmann—La Roche, Inc.

TABLE 1

The Therapeutic Effectiveness of Asterol Powder for Tinea Pedis

Patient	Age	Sex	Initial Severity of Infection	Initial Preparation Used	Results[1] Days	Severity	Asterol Power[2] Results Days
LB	9	F	Mild	C	NC-30	Mild	C-15
CC	6	F	Mild	B	NC-30	Mild	C-16
CS	6	F	Mild	C	NC-30	Mild	C-9
JB	10	M	Mild	A	NC-27	Mild	C-16
AB	8	M	Mild	C	NC-27	Mild	C-10
HC	9	M	Mild	C	NC-27	Mild	R-7
DM	8	M	Mild	B	NC-27	Mild	C-10

(*Continued on following page*)

TABLE 1 (Continued)

CV	13	M	Mild	B	NC-27	Mild	C-10
HC	10	M	Mild	SM	NC-30	Mild	I-21
DF	14	M	Mild	# 28	C-35		
FC	10	M	Mild	OM	NC-30	Mild	C-21
BG	9	M	Mild	OM	NC-60	Mild	C-45
JH	11	M	Mild	OM	NC-21	Mild	C-21
EL	9	M	Mild	# 28	C-30		
LM	10	M	Mild	# 28	C-21		
RM	8	M	Mild	# 28	C-30		
DW	10	M	Mild	# 28	C-60		
CS	7	F	Mild	A	NC-37	Mild	C-9
MAC	12	F	Moderate	C	I-40	Mild	R-7
MT	13	F	Moderate	A	I-18	Mild	C-16
SW	5	F	Moderate	C	I-13	Mild	C-9
JB	4	M	Moderate	A	I-29	Mild	C-10
RU	3	M	Moderate	B	I-29	Mild	C-16
PW	9	M	Moderate	A	I-27	Mild	C-22
LM	9	M	Moderate	OM	I-40	Mild	C-45

(Mild) Mean time to cure — 21.6 days
Per cent cured — 88%

IMC	11	F	Mild	B	R-30	Moderate	C-40
DT	8	F	Mild	B	R-30	Moderate	C-16
RT	5	M	Mild	B	R-29	Moderate	C-22
BW	4	M	Mild	B	R-29	Moderate	C-22
MB	13	M	Mild	OM	R-21	Moderate	C-22
SH	4	M	Mild	OM	R-21	Moderate	C-16
CG	13	F	Moderate	C	NC-30	Moderate	C-45
BJH	12	F	Moderate	B	NC-30	Moderate	C-37
MB	12	M	Moderate	B	NC-27	Moderate	C-21
RG	3	M	Moderate	C	NC-30	Moderate	C-10
JT	4	M	Moderate	A	NC-29	Moderate	C-23
EV	15	M	Moderate	# 28	C-21		
HP	21	M	Moderate	# 28	C-21		

[1] R — regression, NC — no change, I — improved, C — cured.
[2] Same as # 28.

BC	10	M	Moderate	OM	NC-30	Moderate	C-30
MM	11	M	Moderate	# 28	C-53		
JT	5	F	Severe	B	I-30	Moderate	C-22
NG	4	M	Severe	C	I-27	Moderate	C-22
EL	8	M	Severe	C	I-19	Moderate	C-16
RL	12	M	Severe	OM	I-21	Moderate	C-17

(Moderate) Mean time to cure — 23.5 days
Per cent cured — 94%

DF	13	M	Mild	A	R-7	Severe	C-50
BC	10	M	Moderate	B	R-27	Severe	C-16
MS	5	M	Moderate	B	R-29	Severe	C-38
RH	14	M	Severe	B	R-12	Severe	C-22
RL	11	M	Severe	B	NC-26	Severe	NC-16
RL	10	M	Severe	C	NC-26	Severe	C-30
LW	4	M	Severe	A	NC-29	Severe	C-36
PS	11	M	Severe	# 28	C-16		

(Severe) Mean time to cure — 32.0 days
Per cent cured — 75%

All Patients: Mean time to cure — 23.7 days. Per cent cured — 88%.

lowed the unsuccessful use of another preparation or was the initial agent prescribed, although the time to cure was generally greater in the latter. This observation is more pertinent to the mild cases, since too few moderate and severe cases were initially treated with Asterol powder to make an overall generalization.

The mean time to cure all patients, 23.7 days, and per cent cured, 88%, compare favorably with the results obtained with the liquid fatty acid preparations. Thus, when children at St. James Orphanage were treated for tinea pedis with Sopronol®† under comparable conditions, the mean time to cure was 19.3 days and 81.8% were cured (se Scherr, *et al.* 1955).

It is clear that Asterol powder was successful as a therapeutic agent for tinea pedis. We cannot say at this time whether this success could be duplicated for other fungistatic or fungicidal powder preparations or is inherent in the specific agent used here. We believe that a major contributing factor for the favorable results reported might be the fact that this study was done during the summer months and that perspiration mixing with the powder during the course of the day produced the effect of a paste or ointment. There were a few cases in which this powder was used as a therapeutic agent during the winter months with little success, but too few cases are available to warrant any conclusions.

The ease of application of a powder preparation was significant in insuring the periodic use of the prescribed agent by the patient. In our experience, there is more likelihood of the patient's losing patience with the necessity of the periodic use of liquid or ointment preparations than with a powder. Thus, despite the increased time to cure for the powder preparation used here, greater ease of application warrants further observations as those reported here, confirming the advisability of increased use of powder preparations as therapeutic agents for tinea pedis.

†Wyeth Laboratories, Inc.

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Infections from birds

Psittacosis is not a grave danger to public health and treatment with some of the newer antibiotics has been successful. But it can be an alarming and a distressing disease. In our present state of ignorance, prevention will not be easy. Active immunization is possible but few except bird fanciers are likely to ask for it. Without examples plain to see, it would be hard to persuade the public that any harm can come from a bird so elegant and amusing as the little parrots. If pigeons spread the disease this will be one more reason for reducing their numbers. But so far they seem to have defied all methods designed for their annihilation in town and country. Before we are compassed about with any more restrictions and prohibitions it would be wise to try to establish beyond doubt the source of the two infections which are detected each week. *Editorial. Foul Fowl. Lancet, June* 1, 1957.

A Clinical Evaluation of L-Glutavite* in the Treatment of Elderly Chronic Deteriorated Mental Patients

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THE ubiquitous bodily distribution of glutamic acid, and its apparent participation in several metabolically significant processes, have evoked much speculation as to its clinical importance and therapeutic usefulness, particularly in the central nervous system where it is found as a prominent constituent[1]. Various roles have been ascribed to it: accelerator of brain respiration; stimulus to synthesis of acetylcholine; adrenergic substance; and detoxifier of ammonia[2].

Several previous studies from this laboratory have shown that monosodium 1-glutamate is the form in which glutamic acid is best tolerated and absorbed orally[3]. Furthermore, a daily intake of 15 grams in three 5 gram doses is effective in producing significant rises in plasma level and is devoid of the toxic side reactions often encountered with higher dosages[4]. The administration of 5 grams of monosodium 1-glutamate three times daily over a period of eleven months to 27 chronic mental patients of various ages failed to disclose any significant changes statistically in perceptual and motor co-ordination tests. However, 17 patients showed clinical improvement in one or more of the following areas: activity, affect, intellection, socialization, and thinking[5].

Recently L-Glutavite, a "cerebral tonic" for the geriatric patient, containing a mixture of monosodium 1-glutamate 3.48 gm., niacin 45 mg., thiamine mononitrate 0.6 mg., riboflavin 0.8 mg., ascorbic acid 30 mg., ferrous sulfate 11 mg., and dicalcium phosphate 910 mg., has been prepared in packet form by the Gray Pharmaceutical Co. The rationale for this type of therapy has not been established, but some of the empiric reasons are apparent, and have been discussed by others[6,7].

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METHOD

The study reported here sought to determine the therapeutic efficacy of L-Glutavite on the general behavioral adjustment of a randomly selected group of 24 elderly, long-term, chronic, deteriorated psychotic male patients. Their average age was 65 years, and they had been hospitalized on the average slightly over 20 years. Diagnostically the group comprised 10 patients with organic brain syndrome, 9 with functional psychosis, and 5 with mental deficiency.

The patients were divided randomly into two groups, characterized for the most part by passive, regressed, manneristic, idle, apathetic, untidy behavior. They resided on the same feeding ward prior to the onset of the experiment, and except for the addition of the experimental supplemental feedings in chilled tomato juice, there was no apparent substantial change in environmental surroundings, daily routine, and accustomed personal contacts. Psychiatric ward rounds were made daily, and the patients were tested psychologically on three occasions: prior to the onset of the experimental regimen, at midpoint, and again at the end. There was no attempt to change the ward program from the usual routine, and a careful effort was made not to influence the attitude or expectations of the regularly assigned ward personnel.

A "double blind" cross-over technique was utilized with each patient serving as his own control. In the premedication phase all patients received plain chilled tomato juice with their three daily meals. This was continued for a period of three weeks so that all would become accustomed to the vehicle. The two experimental preparations were then introduced in the vehicle —the one containing L-Glutavite, the other an identical vitamin-mineral mixture but no mono-

sodium 1-glutamate. After six weeks the two medications were reversed and continued for an additional six weeks.

Because the previously cited investigations indicated that the minimum effective daily dose for monosodium 1-glutamate by the oral route was 15 grams, the Gray Company's recommended minimal dosage of three packets daily was doubled. Thus, each patient received 20.88 grams of glutamate daily on the average, but with the occasional missed and partially consumed doses inevitable in this type of clinical experiment the actual intake was probably more of the order of 15 grams daily.

Effects were evaluated by a combination of findings from daily psychiatric ward rounds, periodic psychological tests, and multiple independent ratings on a specially devised, simplified, 40 item behavioral check list sampling 10 areas: appearance, behavior, mood, speech, thought, socialization, activity, learning, sleep, and eating. All ward workers including sub-professional personnel contributed to these ratings at regular intervals. None of the raters was given information as to the nature of the medication being used or what possible changes to look for. Nor could they refer back to previous ratings or discuss their opinions with others. In this way it was hoped more objective running evaluations would be obtained. In all 600 ratings were completed on the 24 patients. These were grouped for analysis and comparison by individual patients, raters, and collectively. Trends were scored simply as (0) no change; (+1) minimal improvement; (+2) definite improvement; (−1) minimal impairment; (−2) definite impairment. The individual patient's behavior prior to the onset of the experiment constituted the base line for scoring.

Psychological tests were attempted prior to all medication, and again at the six week cross-over point, and twelve week termination. Five different tests were employed. All were selected for simplicity of comprehension, and brevity of execution, in the hope this would assure greater participation and more reliable performance from an admittedly relatively "untestable" population. The tests included: Wechsler-Bellevue I: digit span and vocabulary subtests; Ravens Progressive Matrices, Scales A and B; Human Figure Drawing; and Ordering of 8 circles according to magnitude of gaps from small to large, a subtest from the Galesburg Deficit Battery.

RESULTS

For all practical purposes there were no management problems nor significant side effects on either supplemental feeding. Only two patients rejected the feedings with any regularity, and this was primarily on a delusional basis. However, one patient did report a slight flushing effect which did not occur with plain tomato juice. This presumably was due to the niacin present in both supplemental feedings in relatively high dosage (90 mg. t.i.d.). There were a few isolated cases of transient gastrointestinal intolerance with vomiting or diarrhea. There were also two instances of localized dermatitis with itching which subsided after brief topical therapy.

Inspection of data revealed no meaningful trends suggestive of improvement or impairment on any of the psychological tests for individuals or groups in either phase of the double blind study. The behavioral check-lists also yielded no meaningful correlations with respect to the two supplemental feedings employed.

However, when the total number of responses on all psychological tests were grouped and subjected to chi square treatment it was found that a somewhat larger result was obtained during periods of L-Glutavite feeding, than during the vitamin-mineral feeding. Neither value was statistically significant. However, since a cross-over technique was followed this could be more than a chance occurrence, and furthermore, it correlated with the presence or absense of monosodium 1-glutamate.

Subjective clinical impressions gained from daily psychiatric ward rounds are somewhat of the same order. A moderate degree of individual improvement was observed in the general activity level, sociability, and participation in ward routine. Untidiness, apathy, and confusion lessened, but intellectual and ideational impairments remained essentially unchanged. While these improvement trends were noted in most patients, and appeared to increase progressively with time, a greater degree of correlation with the use of L-Glutavite seemed apparent.

There also was a general improvement of appetite and moderate weight gain on both regimens, but a somewhat greater weight gain oc-

curred during those periods when L-Glutavite was the supplemental feeding. Several patients spontaneously requested a resumption of supplemental feedings after the experiment was concluded.

Tabular Summary of Results Obtained

	Brain Syndromes	Functional Psychoses	Mental Defectives	Total
Definitely Improved	3	0	1	4
Moderately Improved	5	6	3	14
No Appreciable Change	2	3	1	6
Worse	0	0	0	0

DISCUSSION

Himwich, et al[5] working with 24 chronic mental patients over a period of eleven months found that monosodium 1-glutamate in contrast to placebo produced significant clinical improvement in 17 patients in one or more of the following areas in decreasing order of occurrence: action, emotion, intellection, interpersonal relationships, thought processes, and insight. It also was found that equally good results could be obtained with 5 grams as with 15 grams three times daily, while toxic side reactions sometimes seen with the larger doses were absent. Furthermore, discrepancies in the previous literature could be accounted for by the use of three different forms of glutamic acid which are not equally absorbed into the blood stream.

Barrabee, et al[6] studied 30 aged psychotic female patients using L-Glutavite, Metrazol, and vitamins. It was found that all subjects and groups improved significantly in mental and social behavior, but L-Glutavite was the most effective of the three drugs used. The most outstanding improvements occurred in the categories of sociability, productivity, and thought content. Less outstanding improvements were found in self care, co-operation, affect and mood. The least improvement occurred in intellectual functions.

Katz and Kowaliezko[7] found that of 27 elderly institutionalized patients suffering from a variety of chronic physical and mental illnesses, 12, or 44%, demonstrated good or excellent responses to L-Glutavite therapy in regard to a decrease in apathy, depression, and fatigue, an increase in appetite, motor activity, and sensorium. Six other patients demonstrated a fair but noticeable improvement. In all 18, or 66%, responded favorably to some degree.

Wolff[8] also studied the effects of L-Glutavite in senile patients and reported it more effective in improving their mental function than the combination of Metrazol and niacin. It was especially effective in repressed, listless, apathetic, confused patients with memory defects.

While our findings were not as pronounced as the foregoing, in general they parallel the effects reported by the previous investigators. The fact that we worked with a markedly regressed and unresponsive group of patients, and used a much shorter treatment phase (six weeks as against twelve weeks in previous cited studies) may account for the smaller changes observed and our inability to validate our subjective clinical findings statistically.

CONCLUSIONS

L-Glutavite, a soluble powder containing monosodium 1-glutamate, vitamins, and minerals was administered to a group of 24 chronic, deteriorated, elderly, psychotic, mental patients to assess possible general behavioral therapeutic effects. A "double blind" cross-over technique was employed. Half the patients were fed this medication in chilled tomato juice with all meals while the other half received an identical vitamin-mineral supplement but without monosodium 1-glutamate. Feedings were reversed at six week intervals. Effects were evaluated by a combination of daily psychiatric rounds, psychological tests, and multiple independent ratings on a specially devised behavioral check-list executed by all ward personnel at regular intervals.

Of 24 patients studied 4 showed definite improvement, 14 were moderately improved, and 6 had no appreciable change in general behavior.

While the results are not amenable to statistical validation there appears to be a greater degree of clinical improvement on supplemental feedings with L-Glutavite than on the control preparation as manifested by a moderate increase in activity level, sociability, participation in ward routine, lessened apathy, confusion, and untidiness. Appetite and weight gain paralleled these findings. Intellectual and ideational impairments remained essentially unchanged.

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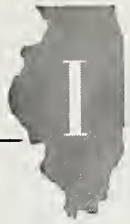
Rheumatic fever concepts

Rheumatic fever is now recognized as a systemic disease characterized by inflammatory lesions that may be widely distributed throughout the connective tissues in various parts of the body. Despite the generalized nature of the rheumatic process, it would be a disease of relatively little significance if it were not for involvement of the heart. This follows from the well known fact that the lesions in most areas, such as the joints, appear to heal completely without detectable residual damage in contrast to those affecting the endocardium, which frequently lead to crippling malformations of the valves. Except for the currently uncommon cases in which overwhelming pancarditis or myocarditis threatens life during the acute phase of the disease, the menace of rheumatic fever can be defined almost solely in terms of these delayed and permanent effects on the valves of the heart. The seriousness of this end result of the disease justifies, and to a large extent stimulates, the continued attempts to clarify the mechanisms involved in the pathogenesis of acute rheumatic fever. *Maclyn McCarty, M.D. Nature of Rheumatic Fever. Circulation. Dec.* 1956.

The origin of isotope

The word isotope, now so familiar, was introduced in Glasgow about 1912 by a medical woman — Margaret Todd, who also was a novelist writing under the name Graham Travers — to fit the concept of elements occupying the same place in the periodic table. The occasion was a social gathering at 11, University Gardens, then the home of Sir George Beilby (father-in-law of the late Frederick Soddy, who originated the concept of isotopes and other achievements in radiochemistry including the first approach to atomic numbers). Having been obliged to use awkward paraphrases to express his isotopic ideas, Soddy said he needed a word for the concept. Dr. Todd immediately suggested isotope — iso, the same, and topos, place. The word indeed had been published a few years before in a context of organic chemistry but there is no reason to suppose that Dr. Todd was aware of that. Purists may like to note that homotope would be more exact. Soddy, however, gratefully adopted the suggestion of isotope and its use in its now accepted sense was first published by him in 1913. *Letters to the Editor. Hugh Nichol. Lancet, June* 29, 1957.

CASE REPORTS



Mobile Lithopedion—A Chance Discovery in Routine X-ray Examination

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"STONE children," or lithipedions, have aroused interest sufficient to stimulate descriptions, drawings, dissections, and analyses for at least 400 years. Nesbitt[1] cites Israel Spach whose work on gynecology in 1557 showed a lithopedion in situ in the opened abdomen of a woman. With many features of lithopedion formation still unexplained, it is easy to understand the aura of mystery attached to the first specimens discovered. Nesbitt[1] believes the grand total of authenticated lithopedions was 258 as of June 1955. The number will not increase much because ectopic gestation is now recognized early and treated surgically, thus removing the almost invariable cause of lithopedion formation.

The latter part of the 19th century saw enormous contributions to descriptive pathology and lithopedions were then classified by Kuchenmeister[2] as follows:

1. The lithokelyphos, in which the membranes alone are calcified and form a shell about an uncalcified fetus.

2. The lithokelyphopedion, in which both membranes and fetus are calcified.

3. The lithopedion in which the fetus is infiltrated with calcium salts and the calcification of the fetal membranes is minimal. Complete extrusion from the membranes may exist and it is thought calcification of the mummified fetus occurs in the adherent vernix caseosa. This author found records of 24 stone children in the first category in women in their 30's who had borne several children. There were three specimens in the second group in women with no additional pregnancies, and 18 children in the third group. The shortest period of carrying a stone child was two years; the longest, 56; and the average, 23 years.

A variation in classification was suggested by Masson and Simon[3] who used the term lithopedion for the entire group. They proposed the term lithotecnon for the true lithopedion. These authors reported nine lithopedions at the Mayo Clinic from 1903 to 1926. Eight of the specimens were removed at operation and one was found at necropsy.

The majority of lithopedions are the result of ectopic gestation. Extrusion of the fetus into the abdomen with variable amounts of covering membranes, or no membranes, lays the groundwork for subsequent calcification. Less credibility has been attached to intrauterine lithopedions in the last century. There was, however, an illuminating report of the latter by Roberts[4] in 1952. His patient, pregnant with twins, developed pain near McBurney's point in the fourth month

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of gestation. Pain subsided gradually and the patient eventually delivered one live 5 lb. 4 oz. (2.4 kg.) female child. Curled around the occiput of this child was a fetus of about four months, almost totally calcified. The placenta contained an infarction, "about the size of a duck's egg" in the place where the cord of the lithopedion inserted. This report is valuable in confirming the fact of intrauterine lithopedion and further demonstrates with experimental clarity the time element of about five months necessary to affect almost total calcification.

The subsequent morbidity of a patient with a ruptured ectopic pregnancy depends on numerous factors such as the amount of hemorrhage, infection, position of the occasional lithopedion, and the effect of the latter on surrounding organs. As indicated by Bacon[5], the danger decreases as the age of the lithopedion increases. Leopold[6] was fully aware of the predisposition of extrauterine fetuses to form stone children. From his experiments with rabbits he surmised that human embryos of as much as three months' gestation would be absorbed. He transplanted rabbit embryos of various ages into the abdomen of rabbit mothers. The youngest embryos were always absorbed while older ones brought about a plastic peritonitis. This experiment succeeded in producing a lithokelyphopedion. The success of these early experiments is all the more remarkable when consideration is given to the fact that lithopedion formation occurs in only 0.81 per cent (Schumann[7]) to 2.0 per cent, (Masson and Simon[3]) of all extrauterine pregnancies. Stander[8] gives the incidence of all ectopic pregnancies as one in 268 pregnancies. The incidence of lithopedion is thus about 1 in 25,000 pregnancies.

Case Report S.S. No. A3950: This patient, a 67 year old white female, was admitted to Holy Cross Hospital with the complaints of anorexia, indigestion, acid regurgitation, and constipation with weight loss of about 8 pounds in the last six weeks. Nausea was present after the evening meal with vomiting at infrequent intervals. Until then the patient felt well with no complaints.

Past history, elicited from her husband, revealed that about 37 years previously, while the patient was washing dishes at the sink, she was seized with severe abdominal cramps and collapsed on the floor. The physician who was called placed her at bed rest with diagnosis of intestinal influenza. Patient remained in bed 10-14 days during which period she was very ill and at times comatose, refusing to eat or eating only by compulsion. After recovering from this illness she remained in good health until the present admission to hospital.

Her menstrual history was not abnormal in any respect. The onset of menses was at 13 years of age; the interval 28 days with 4-5 days of flow and always regular. Her last menstrual period was at age 50 years. The obstetrical history was of Gravida II, Para I with one miscarriage at 3 months gestation some 30 years ago. The patient had never had surgery.

Physical examination on this admission showed a slightly jaundiced woman not acutely ill and in no distress. Temperature 98.6°, blood pressure 170/90. Examination was negative except for a loose, flaccid abdominal wall revealing signs of weight loss and a palpable hard tumor mass over the pyloric region.

Laboratory studies:—Blood count: Erythrocytes 3,300,000 with marked hypochromia and anisocytosis with microcytes predominating. There was polychromatophilia. Leukocytes numbered 8,000 per cu. mm. with lymphocytes 24% and neutrophils 76%. Hemoglobin was 6.95 gms. Coagulation time, 4 minutes. Blood type was Int. A Rh positive. Kahn test was negative.

Blood Chemistry: Blood sugar 119 mg. %; A/G ratio 4.25/1.20 gm; Prothrombin time, 17 seconds; Bleeding time, 2 minutes 35 seconds; thymol turbidity 0.4 units; cephalin flocculation negative; sedimentation rate 60 m.m.; and hematocrit 38.

Radiological Report:—The barium meal of 11/30/55 revealed the stomach to be considerably dilated with evidence of retained food and gastric fluid. The pylorus of the stomach was irregularly narrowed. The stomach emptied with considerable delay. Incidentally noted was



Figure 1. Pyloric lesion is noted with obvious retention of the barium meal. Calcified mass is noted incidentally in lower right abdomen.



Figure 2. Lithopedion well demonstrated and shows unusual mobility.



Figure 3. Lithopedion well demonstrated and shows unusual mobility.

a calcified mass in the lower right abdomen. Twenty-four hour delayed film of the barium meal study revealed marked gastric retention. (Figure 1)

Additional films were taken on 12/8/55 in the supine, Trendelenburg, and right lateral decubitus positions for further evaluation of the calcified mass noted on the original examination demonstrated a lithopedion. The lithopedion shifted slowly from the lower abdomen to the right upper abdomen. This apparently signifies the attachment of the lithopedion to the omentum or mesentery of the small bowel. (Figures 2-3)

Impression

1. Duodenal obstruction due to possible carcinoma.
2. Lithopedion—intra-abdominal and extrauterine.

Surgical Report:—Several days were taken to correct the blood chemistry picture, after which the patient was taken to surgery and under endotracheal anesthesia, a left paramedian incision was made from the xyphoid to below the umbilicus. The abdominal cavity was entered and the distal omentum brought into view. The most distal omentum was attached to the anterior abdominal area of the lithopedion (3-4 months gestation) and freely movable. (Figure 4)



Figure 4. Lithopedion at time of surgery showing omental attachment.



Figure 5. Radiogram of specimen.

The lithopedion was removed. A palliative gastrojejunostomy was done for relief of duodenal obstruction which was due to inoperable carcinoma of the antrum and duodenum. The abdominal wound was closed and the patient returned to her room in good condition.

Pathological Report 1. 12/13/55:—The specimen consisted of a lithopedion in a typical fetal position. The calcified fetus had a rump-crown length of 15 cm. and its arms and legs were applied tightly to the body. Near the midline there was an attachment 9 cm. vertically and from 8 mm. to 12 mm. broad to a portion of omentum now 7 cm. long. No skin investing tissues were recognizable although a translucent membrane covered the bones which are clearly visible beneath. (Figure 5)

Diagnosis: Lithopedion with omental attachment.

Pathological Report No. 2. 12/14/55:—The tissue mass for biopsy was roughly 7 mm. long and 3 to 6 mm. in thickness. In the paraffin section stained with H and E the tissue mass was for the most part composed of fatty musculofibrous elements in which there was an ingrowth of an adenocarcinoma.

Diagnosis: Adenocarcinoma (clinically of the stomach).

Final Diagnosis:

1. Duodenal obstruction due to carcinoma of the stomach.
2. Lithopedion—intra-abdominal and extrauterine.

SUMMARY

1. A lithopedion with marked mobility is described.

2. This "stone child" probably is the result of an ectopic gestation due to rupture of a fallopian tube 37 years previously.

3. The attachment to the omentum indicates the probable vascular supply to the fetus and lack of obstructive symptoms as the lithopedion formed.

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Hallucinatory drugs

Serotonin (5-hydroxytryptamine, 5-HT) contains the indole nucleus but is a natural component of brain and other tissue. It has been labeled a neurohormone. Its exact neurophysiological function has not been determined, but it is suggested that many vital mental processes are mediated via the action of this neurohormone. A deficiency of this metabolite has been implicated as an etiological factor in certain mental dysfunctions. Serotonin injected peripherally into animals does not result in an appreciable increase in the concentration of this compound in brain tissue. Evidently, some chemical precursor of serotonin must be present in order to traverse the blood-brain barrier. Serotonin also is present in smooth muscle of the body. Serotonin is then a metabolite of the body and many hallucinatory drugs have been called antimetabolites, since they have a structure similar to this essential component of the body and it has been suggested that they evoke their physiological response by a deficiency of serotonin. *Francis W. Hughes. Ph.D. New Psychotherapeutic Drugs. J. Indiana M.A. March,* 1957.

Priapism: Report of Two Cases and Discussion of Treatment

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THE term priapism comes from Greek and Roman mythology. Priapus, a god of fertility, was represented as a grotesquely ugly man with an enormous and erect organ. Priapic rites were orgiastic[4].

In 1914 Hinman[6] defined priapism as a remarkable pathological condition of prolonged and persistent erection unaccompanied by sexual desire and usually painful. Treatment of this condition offers a challenge to the urologist.

Priapism may be transient or prolonged. Transient cases last a few hours, subside spontaneously usually without complications, and may recur. Prolonged cases may persist for several days or longer. Thrombosis of the corpora cavernosa occurs with persistence of the erection.

Although the majority of cases are idiopathic in origin a wide variety of etiological factors have been reported. Priapism has been reported as a complication of tularemia[5], transurethral resection of the prostate[1], and tetanus antitoxin injection[7].

There is no one completely satisfactory classification of the causes. In his 1914 paper Hinman[6] classified them into:

I. Neurological:
   A. From ascending peripheral stimuli (reflex)
   B. From direct stimuli:
      1. To the spinal cord center
      2. To the nervi erigens or pudendi
   C. From descending peripheral stimuli
      1. Direct
      2. Indirect

II. Mechanical:
   A. Thrombosis or pseudothrombosis
   B. Hemorrhage or hematoma
   C. New growths of penis
   D. Inflammatory swelling and edema of penis

In 1943 Cave[3] classified the causes into:

1. Primary: posterior urethritis, local malignancy, bladder stones.

2. Secondary: leukemia, multiple sclerosis, CNS syphilis, neurasthenia, sickle cell anemia.

In 1950 Abeshouse and Tankin[2] recorded the total number of reported cases as 378 up to that time. Although priapism is rare and the number of reported cases is relatively small, most urologists with a large experience have seen several cases.

The following are reports of two cases:

Case No. 1: A 19 year old white male was admitted to SAFB Hospital on January 6, 1955, with a painful, persistent erection of the penis of six day's duration. He had sustained a minor degree of trauma to the penis three weeks prior to admission as a result of perverse sexual practices. There were no urinary symptoms. Past history was noncontributory.

Temperature was 101.0°F. Physical examination was essentially normal except for a rigid, erect penis tender to palpation.

Urinalysis, blood count, WBC and differential, bleeding and clotting time, prothrombin time, and NPN were normal. Kahn and tularemia fixation tests were negative. A moderate leukocytosis and elevated sedimentation rate were present. *B. protcus* was obtained from the blood culture and corpora cavernosa aspiration. Flat plate of the abdomen and chest x-ray were essentially negative.

Medical treatment consisting of cold compresses to the penis, sedation, estrogens, hexamethonium, cortisone, anticoagulants, and antibiotics failed to give relief.

Spinal and Pentothal® anesthesia were ineffective. Multiple aspirations of the penis were performed under Pentothal anesthesia. A total of 180 cc. of black, thick, stringy blood was removed during these aspirations. It was necessary to perform a dorsal slit. Only temporary regression of the erection occurred with the first two aspirations. Bright, red blood was obtained on the third aspiration. The penis remained flaccid except for a firm mass in the right perineal area which gradually regressed. To date the patient has been impotent.

Case No. 2: A psychotic 40 year old white male was transferred to Hines Veterans Administration Hospital, Psychiatric Service, from Danville Veterans Administration Hospital, Psychiatric Service, on October 5, 1956, with a 10-day history of priapism. On September 21, 1956, he had a biopsy of a growth on the left medial

From Urology Service, Hines Veterans Administration Hospital

malleolus with a pathological report of chronic osteitis. Blood culture, one week following the biopsy, revealed *E. coli.* It was impossible to obtain a history from this patient due to his psychotic state.

Temperature was 100.5°F. Physical examination was essentially negative except for an erect, rigid penis tender to palpation and a firm, tender mass in the region of the left medial malleolus.

Urinalysis, serology, blood count, bleeding time, coagulation time, and prothrombin time were normal. There was a moderate leukocytosis with a normal differential. Chest X-Ray and flat plate of the abdomen were essentially normal. X-rays of the left ankle were consistent with an osteochondroma of the left ankle.

On October 10, 1956, under Pentothal anesthesia, the corpora cavernosa were aspirated using a No. 16 gauge needle. Forty cc. of black, thick, stringy blood was aspirated from the penis. On October 12, 1956, it was necessary to repeat the aspiration because of persistence of the erection. At this time another 30 cc. of black, thick, stringy blood was aspirated. A dorsal slit was performed at the time of the second aspiration. Culture of the aspirated blood revealed *E. coli.* Following the second aspiration the erection gradually regressed and the penis has remained flaccid. To date this patient has been impotent.

On December 11, 1956, a repeat biopsy of the left medial malleolal mass was performed. The pathological report revealed (1) osteochondroma of the bone and reactive scar tissue, and (2) chronic proliferative synovitis of the synovia from the sheath of the posterior tibial tendon.

DISCUSSION

In the first case it was believed the priapism was a result of thrombosis of the corpora cavernosa secondary to trauma incurred during perverse sexual practices. In this case the priapism was followed by a bacteremia. In the second case it was believed a bacteremia from an osteitis of the left medial malleolus caused a thrombophlebitis of the dorsal vein of the penis which in turn produced thrombosis of the corpora cavernosa with resultant priapism.

Numerous methods of treatment of priapism have been proposed. Some, in addition to aspiration of the penis, are incision and drainage of the penis, division of the ischiocavernosus muscle, anticoagulants, ligation of the dorsal arteries of the penis near the pubis, female hormones, and cortisone. Anesthesia of any type is of no avail once thrombosis of the corpora cavernosa has occurred. Mckay and Colston[8] state that thrombosis occurs if priapism exists for more than two days and believe that regardless of the cause priapism should be treated by some method that will remove the thrombosis. Once thrombosis of the corpora cavernosa has occurred aspiration or incision and drainage of the penis are the only satisfactory methods of treatment, regardless of the underlying cause of the priapism. Corpora cavernositis is a serious complication of aspiration and incision and drainage of the penis. The end result of most cases of prolonged priapism is impotence.

The physiology of erection is not completely understood. It is likely the treatment of priapism will remain imperfect until the complex neurological and mechanical factors governing erection are explained.

SUMMARY

1. Two unusual cases of priapism have been presented. One was due to trauma following perverse sexual practices. The second case was the result of a bacteremia originating from an osteitis of the left ankle. Treatment in both cases consisted of aspiration of the penis. As an end result both patients have been impotent.

2. The majority of cases of priapism are idiopathic in origin.

3. Priapism may be transient or prolonged.

4. Two classifications of the causes of priapism are presented.

5. Once thrombosis of the corpora cavernosa has occurred, aspiration or incision and drainage of the penis are the only satisfactory methods of treatment.

6. Treatment is imperfect and probably will remain so until the physiology of erection is completely understood.

7. The end result of most cases of prolonged priapism, regardless of the etiology or treatment, is impotence.

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EDITORIALS

Cancer prophylaxis

Evidence shows that cancer cells escape into the blood during surgical removal of a malignancy. This spillage affects the prognosis even in patients who have a fair change of survival; some individuals succumb to widespread metastases even though the lesion appeared to be well localized at the time the operation was performed.

Cancer cells have been isolated in and near surgical wounds. When the surgical field is flushed with saline, malignant cells are found in the washings. They are isolated also from the blood in veins draining the cancerous area. Now and then they are found in the general circulation postoperatively.

These observations led Warren H. Cole and his surgical associates at the University of Illinois College of Medicine to conduct the following experiments in cancer prophylaxis: They injected from 110,000 to 220,000 cancer cells into the portal veins of rats. One-half were treated at specific intervals with nitrogen mustard or thioTEPA. The other half were used as controls. Cancer cells were isolated in only 7.1 per cent of the treated animals but in 90 per cent of the untreated.

Similar prophylaxis is being used on humans operated on for cancer of the breast, colon, rectum, and stomach. The vessels leading to and from the malignancy are ligated. Half of the initial dose of nitrogen mustard is left in the abdomen and the other half is administered intravenously at the end of surgery. Additional amounts are given daily for three days thereafter.

The project also has caught the imagination of the National Cancer Institute of the U. S. Public Health Service. They are running a large crash project to bring the program to a close as soon as possible, and are using thioTEPA.

This type of research is fundamental and was proceeded by basic animal experimentation and logical clinical judgment. Nitrogen mustard and thioTEPA are toxic drugs and severe reactions occur occasionally. When the results are tabulated, we will know whether this procedure should be adopted.

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Reports of Asiatic influenza coming closer to home

With reports of outbreaks of Asiatic influenza, which first appeared in the Far East in April, bringing the problem closer to home, Illinois physicians must prepare to handle possible epidemic situations in this state.

The Public Health Service of the United States Department of Health, Education and Welfare, each week is reporting a spreading of the disease. From Hong Kong, influenza has spread to other Asiatic countries, necessitating the closing of schools in many places. Millions of cases have been recorded. Attack rates have

approximated 20%, with case fatality rates running around 0.2%.

The disease has been noted in American Army installations and youths camps. Illness clinically resembling influenza also has been reported among passengers and crews of several ships en route to United States ports. Generally, these outbreaks have affected about 10 to 15 % of the persons aboard, and the outbreaks have about run their course by the time of docking on the west coast. Under the circumstances, Illinois cannot hope to escape some cases, if not an epidemic.

Surgeon General L. E. Burney of the U. S. Public Health Service, in a recent letter to Dr. Roland R. Cross, Illinois director of public health, announced the undertaking of an extensive educational and promotional campaign to encourage the maximum use of influenza vaccine on a voluntary basis as quickly as it becomes available. The American Medical Association and the Association of State and Territorial Health Officers will join in this program.

Gen. Burney said that Army medical teams investigating the early epidemics noted that the isolated virus appeared unusual in laboratory tests. Further analyses demonstrated that the virus is type A, but is quite different, antigenically, from any previously known type A strains.

"No protective antibody could be demonstrated in sera from human beings repeatedly vaccinated with previously known type A strains," he said. "Thus our people are probably highly susceptible to this new Asiatic strain of influenza and previously made vaccine offers no protection."

It is generally conceded that the virus is now widely seeded throughout the country. History suggests that the spread of the disease will accelerate with the advent of cold weather. The epidemic is likely to strike most areas almost simultaneously.

The only means of prevention is an influenza vaccine containing the Asiatic strain of virus. Manufacturers were up against it when the strain variant appeared but they are now able to produce a satisfactory monovalent vaccine and are currently working on a large scale production basis.

Dr. Cross has taken cognizance of this situation and in a recent public statement urged everyone to take advantage of the opportunity to be vaccinated. This, he said, should be done as soon as the vaccine is available. The Department of Public Health will not be able to furnish this on a free distribution basis because of limited funds for the purchase of vaccines, he added.

"There is no assurance that the virulence of the influenza virus will not increase so that illness will be much more severe than the relatively mild illness caused so far this year by the Asiatic strain now widely disseminated in America," he said.

"Every possible precaution is being taken to prevent the disease and to be prepared to alleviate suffering if a major epidemic does take place."

The Council on Public Health of the American College of Chest Physicians has issued a report on the situation because its members will have a definite role to play in the surveillance and control of influenza. It said:

"Although individual cases of influenza are not required to be reported by a physician, in order that the first signs of an outbreak can be detected, physicians should call health officers about suspected and proved cases occurring this summer and fall."

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Protection against influenza by intracutaneous injection

With the increasing interest in influenza immunization being stimulated by the epidemic from Asia, I am sure there will be an increase in the demand for influenza virus vaccine. Knowing of our national experience with poliomyelitis vaccine and the associated problems of shortages of vaccine, I am wondering whether or not serious consideration has been given to the intracutaneous method of influenza immunization.

If and when an influenza epidemic occurs there will no doubt be a terrific shortage of influenza virus vaccine. With the use of 0.2 cc. followed by 0.1 cc. intracutaneously, at an interval of time of seven days to two weeks, six times as many people could be immunized as if 1.0 cc. were given intramuscularly in two separate injections. It has been my experience during the past decade that as much protection was

received by this intracutaneous method as with the larger dosage intramuscularly, and with a great deal less reaction to the vaccine. The intracutaneous method has been successful not only in the work of the preventive corps of the navy but has had extensive trial and success in Denmark in much of its preventive work.

E. A. Piszczek, M.D.

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Society exhibit popular at Illinois state fair

The exhibit of the Illinois State Medical Society at the Illinois State Fair in Springfield, August 9-18, was exceedingly well patronized.

"Traffic and Highway Safety" was the theme, and the public displayed keen interest in what the medical profession is doing to cut down the terrific toll of dead and injured.

Members of the Woman's Auxiliary to the Sangamon County Medical Society who staffed the exhibit, and representatives of the division of traffic safety of the State of Illinois who handed out cards pledging observance of traffic laws and highway regulations, were kept busy.

"It was one of the best displays we have ever had," said Dr. Jacob E. Reich of Springfield, whose hard work and planning makes possible the presentation of a successful exhibit.

The exhibit informed the public how it can help cut the traffic toll. There were displays of highway hazards. Attention was called to the dangers of driving if drinking. One panel showed the influence of alcohol on the brain and another, a person's delayed reaction time. In addition, there were continuous motion pictures portraying various phases of accident prevention and safety measures.

The Illinois State Medical Society this year has gone all out to aid in the Governor's traffic accident program, and the Fair exhibit was in line with that policy. No one knows any better than physicians the suffering and misery brought about by automobile accidents.

Consequently, it was most appropriate that in this year's display emphasis was placed on ways to reduce the volume of deaths and injuries. Judging by the comments of those attending the Fair and visiting the Society's booth, the public is most appreciative of the efforts of medicine.

Thousands went away, impressed more than ever by the fact that speed and alcohol are the biggest factors in the heavy death and injury toll.

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A.M.A. makes official changes at top administrative level

In a change at the top administrative level of the A.M.A., Dr. George F. Lull of Chicago was elevated to the newly-created position of assistant to the president. Dr. Lull has been secretary-general manager of the A.M.A. for the last 11 years and will continue in the elective office of secretary.

At the same time, Dr. F. J. L. Blasingame of Wharton, Tex., was appointed by the Board of Trustees to the position of general manager. Dr. Blasingame, who is well known to Illinois medicine, will take over his duties on January 1, 1958.

Dr. Blasingame, who is 50, was elected to the A.M.A. Board of Trustees in 1949, being one of the youngest physicians so chosen. He served as president of the Texas State Medical Association in 1955. Graduating from the Texas Medical School, Galveston, in 1928, he spent three years as a teacher on the medical school staff. He has since maintained a teaching connection at the university.

In announcing the selection of Dr. Blasingame, Dr. Edwin S. Hamilton, Kankakee, Ill., chairman of the A.M.A. Board of Trustees and councilor of the Illinois State Medical Society, said:

"The 164,000 members of the American Medical Association are fortunate in obtaining the services of Dr. Blasingame. He is young, highly experienced, and he is making the change at a great sacrifice to himself. . . . He is dedicated to the principles of good medical care for all of the American people. He possesses all the essentials of leadership, plus knowledge, imagination and sound thinking. His work on behalf of medicine through the years has shown that he has the courage and initiative to shoulder responsibility."

Dr. Lull, in his new office, will relieve the president of the Association of many of the burdens of this office, which have become especially heavy in the last few years. Dr. Hamilton said:

Dr. Lull will s e r v e as spokesman, trouble-

shooter, listening post, information center and as an ambassador of the medical profession in cities and towns throughout the country. His experience is invaluable, and it will be applied in solving medical problems at the state and local level, as well as nationally.

Dr. Lull, 70, joined the A.M.A. staff after serving 34 years in the Army. He has a distinguished military service, emerging as major general of the Army Medical Corps. His last position before retirement was deputy surgeon general of the Army.

His host of friends in the medical profession in Illinois extend to him congratulations on a well-deserved promotion.

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Cameron Parish Medical Rehabilitation Fund

Many millions of American people were thrilled with the news reports on the work of Dr. C. W. Clarke of Cameron, La. During hurricane Audrey, the small town of Cameron was almost completely destroyed. Three doctors worked around the clock for several days in their efforts to save lives and repair physical damage to hundreds of survivors.

CAPSULES, the official newsletter of the Louisiana State Medical Society in its issue of August 1, gave the following information on efforts to aid in the rehabilitation of the facilities of the three physicians who aided so materially in caring for victims of the hurricane.

"Members who have not already made contributions to the Cameron Parish Medical Rehabilitation Fund are urged to send checks at once. The fund was established by the Louisiana State Medical Society to provide financial assistance to three young physicians who lost their homes and offices while rendering emergency medical care to the citizens of Cameron Parish during hurricane Audrey. It is hoped that the fund will speed reconstruction of the offices of Dr. C. W. Clarke of Cameron, and Drs. S. E. Carter and G. W. Dix of Creole and thereby restore normal medical service to people of the storm-ravaged area. The fund was established as a tribute to all physicians of the area who performed in the best traditions of the profession during and after the hurricane.

Send your checks to Cameron Parish Medical Rehabilitation Fund, c/o Louisiana State Medical Society, Room 105, 1430 Tulane Avenue, New Orleans 12, La.

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Revised and added sections of the mental health code as enacted by the 70th General Assembly

Section 4-2. Upon admission of such a person to the hospital, the Superintendent thereof shall inform the patient, and his relatives, parents, guardian, or attorney, if any such persons accompany the patient to the hospital, in simple non-technical language, that the patient has the right to leave the hospital 30 days after giving the Superintendent thereof notice in writing of his desire to leave, and the Superintendent of the hospital shall release such patient within 30 days after receipt of such notice, unless the patient shall within such 30 days, in writing, withdraw his notice; provided however that if a petition is filed for court commitment of such patient within 30 days after the receipt by the Superintendent of a notice of the patient's desire to leave, such patient may be detained by the Superintendent not longer than 5 days beyond such 30 day period pending a final order of the court in the court commitment proceedings; provided, further, that should the said proceedings be continued at the request of the patient then such patient may be detained while such proceedings are continued; provided, further, that a patient admitted to a hospital on a voluntary application for a third voluntary admission or for a fourth voluntary admission may not give such notice until he has been in the hospital for 90 days, and a patient admitted to a hospital on a voluntary application for a fifth voluntary admission or for any other additional voluntary admission thereafter may not give such notice until he has been in the hospital for six months. (As amended by Act approved July 8, 1957).

Section 6-7. If the Superintendent shall find any patient admitted on an emergency petition to be without mental illness, or not in need of mental treatment, or if for any other reason such patient is found by the Superintendent to be not a fit subject for care, treatment and detention in a hospital for the mentally ill, or if such patient shall recover from his mental illness, or be improved to such an extent that he is not in need of further mental treatment, the Su-

perintendent shall discharge such patient. (As added by Act approved July 8, 1957).

Section 7-11. When the Superintendent of any State hospital to which a mentally ill or mentally deficient person, or person in need of mental treatment has been admitted upon commitment to the Department, shall in writing notify the Court entering the original order committing such person to the Department that such person has been conditionally discharged from such hospital, or has been granted an absolute discharge as improved or unimproved, such person may, at any time after his discharge, file a petition in the Court under the provisions of Sections 7-1, 7-2 or 7-3 of this Act, as the case may be. Provided, however, that the notice shall be accepted in lieu of the physician's certificate required by said sections.

In no case shall an absolute discharge as improved or unimproved be construed as a conditional discharge, but a person receiving an absolute discharge as improved or unimproved shall be finally and completely released from the person, hospital, or Department to whom or to which such person has been committed. (As amended by Act approved July 8, 1957).

Section 7-12. If any patient conditionally discharged or boarded out be not returned to the hospital from which such patient was so conditionally discharged or boarded out within one year after the expiration of the period for which such patient was so conditionally discharged or boarded out, then such patient shall be considered to be absolutely discharged, and the Superintendent of the hospital from which such patient was conditionally discharged or boarded out shall so notify the Court having original jurisdiction of such patient and the Court upon receipt of such notice shall enter an order discharging such person; provided, that if the Superintendent or Department desires a continuation of the conditional discharge or boarding out of any mentally ill or mentally deficient person, or person in need of mental treatment, notification of such intent within such year after the period for which such person was conditionally discharged or boarded out, shall be sent to the Court having original jurisdiction of such person; provided, further, that it shall not be necessary for such continuation that such person return to the hospital from which he was so conditionally discharged or boarded out. (As amended by Act approved July 8, 1957).

Section 9-20. The rate at which the sums for the care treatment, detention and training of patients in the State hospitals shall be calculated by the Department is the average per capita cost of the care, treatment, detention and training of all such patients, such cost to be computed by the Department on the general average per capita cost of operation of all State hospitals for the mentally ill and the mentally deficient for the fiscal year immediately preceding the period of State care for which the rate is being calculated; provided that the Department may, in its discretion, set the rate at a lesser amount than such average per capita cost. Less amounts may be accepted by the Department when conditions warrant such action or when offered by persons not liable under this Act. Three-fourths of the amounts so received shall be deposited with the State Treasurer and placed in the Mental Health Fund. The balance, not exceeding the sum of one million dollars per fiscal year, shall be retained by the State Treasurer, ex-officio, as trustee, in a Psychiatric Training and Research Fund outside the State Treasury and shall be expended for training of psychiatric personnel and for research in mental illness or mental deficiency by the Psychiatric Training and Research Authority. If, at any time, the Psychiatric Training and Research Fund unallocated for pending research shall exceed the sum of two million dollars, such excess of said fund shall be restored to the Mental Health Fund. When the amount retained by the Department in any one fiscal year in the Psychiatric Training and Research Fund shall equal one million dollars, all amounts collected thereafter for the remainder of that fiscal year shall be deposited with the State Treasurer and paid into the Mental Health Fund.

The Auditor of Public Accounts shall audit or cause to be audited all amounts collected by the Department and all expenditures from the Psychiatric Training and Research Fund. Disbursements from such fund shall be made as nearly as possible in the manner prescribed in Section 9 of "An Act in relation to State finance", approved June 10, 1919, as amended. (As amended by Act approved July 8, 1957).

Section 9-26. It shall be the duty of the At-

torney General to defend all actions and proceedings against the Director, any state mental health executive, any state hospital superintendent or any assistant state hospital superintendent, arising out of their official duties in connection with the apprehension, transportation, examination, treatment, detention, or discharge of any individual under the provisions of this Act, in any of the courts of this State or the United States. (As added by Act approved July 8, 1957).

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New A.M.A. exhibits

Three new exhibits were previewed at the A.M.A.'s 1957 Public Relations Institute held in Chicago August 28-29. These are available for bookings by state and county medical societies.

(1) "Digestion"—shows the organs involved in digestion, the passage of food through the body, the mechanics of swallowing, the action of the stomach and intestines, and the body's absorption of food.

(2) "Alcoholism is Your Business"—(for professional audiences) gives the viewer an opportunity to eavesdrop on a conversation between a distraught spouse and the family physician over the treatment of alcoholism.

(3) "Organs of the Human Body"—three dimensional models of the torso show location of various organs in the body and their functions.

Societies desiring additional information on these interesting exhibits should write to the A. M.A. Bureau Exhibits.

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Non-group membership in Blue Cross — Blue Shield

It was recently announced by the Medical Director of Blue Cross-Blue Shield, that in answer to thousands of folks who cannot join the plans through a group. . . Blue Cross and Blue Shield will hold a non-group enrollment for individuals and their families in the near future.

Anyone interested in enrolling under the proposed new plan, may receive inquiry slips and complete information about the coming campaign by addressing Blue Cross—Blue Shield, 425 North Michigan Avenue, Chicago 11, Ill.

Physicians desiring a supply of these slips to place on their waiting room table, or to send out with statements, may receive the desired number by addressing the Plans at the above address.

Many people unable to get this fine insurance through lack of a group will be pleased to receive this information and it is hoped that physicians in Illinois will give this information to their patients.

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California, Hawaiian holiday

Members of the Illinois State Medical Society who will attend the annual meeting of the American Medical Association in San Francisco next June, will be assured superior railroad accommodations.

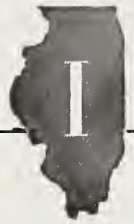
The California Zephyr, with its Vista Domes and ultramodern appointments, has been selected by the Council as its official train. In turn, the Burlington Railroad has given assurance that desirable space, which is usually taken up months ahead, will be set aside for physicians from Illinois.

The railroad also is planning to provide a post-A. M. A. meeting tour of the Hawaiian Islands. Going will be by air from San Francisco and the return trip by the palatial S. S. Lurline.

Details of both trips will be given in later issues.

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CORRESPONDENCE



North Shore Hospital lecture series

The eighth annual series of the North Shore Hospital lectures begins Wednesday October 2 and continues on the first Wednesday of each month through June 1958. Lectures begin at 8:00 p.m. The address is 225 Sheridan Road, Winnetka. Samuel Liebman M.D., has announced that each speaker will answer questions from the floor.

Oct. 2, 1957. **The Psychology of Pregnancy and Parent-Child Relations During Infancy. Therese Benedek, M.D.,** Staff Member, Institute for Psychoanalysis, Chicago.

Nov. 6, 1957. **Management of Eating, Sleep, and Rhythmic Habits. Julius B. Richmond, M.D.,** Professor and Chairman, Department of Pediatrics, State University of New York, College of Medicine, Syracuse, New York.

Dec. 4, 1957. **Management of Learning Difficulties and Speech Disturbances. Margaret Hall Powers, Ph.D.,** Director, Bureau of Physically Handicapped Children and Division of Speech Correction, Board of Education, Chicago; Past President, American Speech and Hearing Association and Division of School Psychologists, American Psychological Association.

Jan. 8, 1958 (2nd Wed.). **Management of Problems of Social Adjustment and the Misbehaving Child. Harry M. Segenreich, M.D.,** Clinical Assistant Professor of Psychiatry, University of Illinois College of Medicine; Faculty of Child Care Program and Clinical Associate, Institute for Psychoanalysis.

Feb. 5, 1958. **Management of Puberty and the Sexual Drives in Adolescence. Adelaide McF. Johnson, M.D.,** Associate Professor of Psychiatry, University of Minnesota, Rochester, Minnesota.

Mar. 5, 1958. **Management of Social Adjustment and Behavior Problems in Adolescence. Joseph B. Cramer, M.D.,** Associate Professor and Director of Child Psychiatry, Albert Einstein College of Medicine; Director of Child Psychiatry, Bronx Municipal Hospital Center.

Apr. 2, 1958. **Management of the Delinquent. Joseph J. Michaels, M.D.,** Training Analyst, Boston Psychoanalytic Society and Institute, Inc.; Visiting Psychiatrist, Beth Israel Hospital, Boston; Instructor in Psychiatry, Harvard Medical School.

May 7, 1958. **Management of the Neuroses of Adolescence. Eugene I. Falstein, M.D.,** Clinical Professor of Psychiatry, Chicago Medical School; Attending Psychiatrist, Michael Reese Hospital; Chief of Child and Adolescent Care, Institute for Psychosomatic and Psychiatric Research and Training, Michael Reese Hospital Medical Center.

June 4, 1958. **Management of the Emotional Problems of the Physically Handicapped Child. William Cooper, M.D.,** Associate Attending Orthopedic Surgeon, New York Hospital; Assistant Professor Clinical Surgery, Cornell University Medical School.

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Clinics for crippled children listed for October

Twenty two clinics for Illinois' physically handicapped children have been scheduled for October by the University of Illinois, Division of Services for Crippled Children. The division will count 16 general clinics providing diagnostic orthopedic, pediatric, speech, and hearing examination along with medical, social, and nursing services. There will be three special clinics for children with cardiac conditions, two for

children with rheumatic fever two for cerebral palsied children.

Clinics are held by the division in co-operation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

The October clinics are:

October 2—Alton (Rheumatic Fever), Memorial Hospital
October 2—Hinsdale, Hinsdale Sanitarium
October 8—East St. Louis, Christian Welfare Hospital
October 8—Peoria, Children's Hospital (St. Francis)
October 10—Cairo, Public Health Building
October 10—Springfield, St. John's Hospital
October 11—Chicago Heights (Cardiac), St. James Hospital
October 15—Danville, Lake View Hospital
October 15—Quincy, Blessing Hospital
October 16—Chicago Heights (General) St. James Hospital
October 16—Elmhurst (Cardiac), Memorial Hospital of DuPage Co.
October 17—Flora, Clay County Hospital
October 17—Rockford, Rockford Memorial Hospital
October 18—Evanston, St. Francis Hospital
October 22—Belleville, St. Elizabeth's Hospital
October 22—Peoria, Children's Hospital (St. Francis)
October 23—Elgin, Sherman Hospital
October 23—Springfield (Cerebral Palsy), Memorial Hospital
October 24—Bloomington a.m. (General), p.m. (Cerebral Palsy), St. Joseph's Hospital
October 24—Mt. Vernon, Masonic Temple
October 25—Chicago Heights (Cardiac), St. James Hospital
October 29—Effingham (Rheumatic Fever), St. Anthony Hospital

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Emergency hospital displayed

A mobile emergency hospital caravan, sponsored by the Illinois Department of Public Welfare in co-operation with the Illinois Civil Defense Agency, the first of its kind in the United States, had its premier showing at the Illinois State Fair, Springfield, August 9-18. It also was shown at the DuQuoin State Fair, August 25 to September 2.

Representatives of the Illinois State Medical Society and the Chicago Medical Society were present at the introduction of the caravan. Dr. Otto L. Bettag, director of the welfare department, said the hospital will be available for such



Illinois has first mobile emergency hospital in the United States.

disaster as epidemics, floods, tornadoes, and fires.

The caravan contains a representative portion of equipment and facilities for a 200-bed Civil Defense emergency hospital. The FCDA has allocated 132 units to Illinois. These are to be stored at various locations. A unit is to be used for training purposes at meetings of local CD groups, medical and nursing societies.

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Postgraduate courses on diseases of the chest

We wish to announce that the Council on Postgraduate Medical Education of the American College of Chest Physicians will present the following Postgraduate Courses on Diseases of the Chest this fall: 12th Annual Postgraduate Course, Hotel Knickerbocker, Chicago, Illinois, October 21-25; 10th Annual Postgraduate Course, Park-Sheraton Hotel, New York City, November 11-15; 3rd Annual Postgraduate Course, Ambassador Hotel, Los Angeles, California, December 9-13.

Tuition for each course is $75. Recent advances in the diagnosis and treatment of chest diseases—medical and surgical—will be presented.

Further information may be obtained by writing to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

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The Academy of Psychosomatic Medicine

The program of the fourth annual meeting of The Academy of Psychosomatic Medicine to be held October 17-19, 1957, at the Morrison Hotel in Chicago will be devoted to "Psychosomatic Aspects of Obstetrics, Gynecology, Endocrinology and Diseases of Metabolism." The meeting will be open to all scientific disciplines, as well as psychologists, social workers and nurses. Information may be obtained from Dr. Ethan Allan Brown, President, 75 Bay State Road, Boston 15, Massachusetts.

This is the first meeting ever held in this country where every one of these specialties will be presented by a multi-disciplinary approach. The panels and symposiums will include obstetricians, gynecologists, endocrinologists, periodontists, psychiatrists, psychologists, anesthesiologists and other specialists in various fields of medicine. There will also be 24 round tables covering all aspects of the above specialties.

The purpose of the Academy is to teach psychosomatic medicine in a manner assimilable to the general practitioner and non-psychiatrically oriented physician.

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"Study abroad" tour theme

"Study Abroad" will be the theme of the third world tour, postgraduate clinical course, sponsored by the International College of Surgeons.

The professional trip will leave San Francisco October 20, and will circle the globe in 48 days. The return to New York will be December 7, with optional return routings to permit stopovers in many European cities. Luxury air lines will be used, and families and friends will be accommodated. Clinical demonstrations will be provided in Hong Kong, the Philippines, Thailand, India, Turkey and Greece.

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School health conference

The sixth National Conference on Physicians and Schools, sponsored by the AMA's Bureau of Health Education, will be held at the Moraine-on-the-Lake Hotel, Highland Park, Ill., October 30 to November 2.

The theme, "A Decade of Progress in Fitness," will emphasize a continuing interest in the health of children and youth. More than 60 nationally recognized consultants and research persons will lead discussion groups.

Topics to be considered will include: the physician's role in youth fitness; mental and emotional aspects of fitness; medical guidance in girls' recreation programs; special health problems in athletics; home and family relations and food factors in fitness.

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Canada's new health service

After 30 years' consideration, Canada has taken the first step toward a national health service with a hospital care insurance plan that is to come into action early in 1959. Six out of 10 provinces, containing more than half the country's population, have signed agreements with the Dominion government to set up hospital insurance systems to be financed jointly by the Dominion and provincial governments. With six provinces participating, the cost to the Dominion will be $100 million a year, a sum expected to be doubled when all 10 provinces join in. The proposed plan includes standard ward care in general hospitals, with some diagnostic service and treatment, and care for the chronically ill. Benefits will be unlimited and cover universal but treatments in tuberculosis sanatoria and mental hospitals will be excluded. At present, 9 million people — about two-thirds of the population — have some form of prepaid hospital insurance from a wide variety of sources. Two provinces have a universal compulsory insurance system financed by premiums and sales taxes while two others have voluntary plans for certain areas. Five plans for prepaid care, sponsored by hospital associations, give service benefits to participants, and many commercial insurance companies also are in the field, offering set cash indemnities against sickness and accidents. But the nongovernmental agencies provide only limited benefits and since their cover is directed mainly toward groups of employees, the rural population and the self-employed can gain protection only through the high premiums set for individuals. Cover for medical and surgical care is even more diversified than for hospital care and much less adequate. Some provinces provide for the treatment of specific diseases such as tuberculosis, cancer, poliomyelitis, venereal disease, and mental illness — free or on a means test — and some provide free medical care for pensioners and people receiving public assistance. On the prairies and in the maritimes, a number of municipalities have salaried community doctors and a few industries have company doctors. Commercial companies also insure against medical costs. A million and a half people are enrolled in eight plans for prepaid medical care sponsored by doctors' associations as an alternative to state medicine. These latter plans are the most popular and give the most comprehensive benefits. But, like the plans operated by hospital associations, their cover is confined so far to groups of employees. Since hospital expenses usually are the heaviest part of medical costs to the patient, the new hospital-care insurance plan meets the strong demand for some provision against the risks of illness — and meets it in a politically safe area. The Dominion government has firmly stated that it will not control or interfere with the hospitals. Doctors, though opposed to any state plan for complete medical care, have generally approved prepaid hospital care where it has been tried. The introduction of a comprehensive medical service is not of course prevented by resistance only from professional bodies. Under Canada's federal constitution, matters of health and welfare are a provincial responsibility; and even with the Dominion government footing half the bill, the poorer provinces could not assume the tax burden of a complete health service. *Editorial. Developments in Canada. Lancet, May* 11, 1957.

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Kid gloves for executives

The wise organization, Medvei says, will insist on its executives having enough leisure, holidays, secretarial help, and comfort in travel and at work. (A New York textile firm has lately announced that its senior executives are to be given a week's holiday every seven weeks.) Thus hours and methods of work should be adapted to the individual; one man will do as much in an hour (and be as exhausted at the end of it) as another in four hours; one works best at night, another in the morning. Some firms have a scheme for regular medical examinations, even including X-ray and laboratory tests. But Medvei points to the danger of such overhauls; on the one hand they make for a false sense of security, and on the other they make people conscious of their health and worried about it. Morever, an examination is not much use unless the physician is acquainted with the subject's background and the stresses he meets. *The Health of Executives. Lancet, May* 11, 1957.

THE P. R. PAGE



Edward A. Uzemack, Director of Public Relations

"Anything a man thinks on, or thinks about, is an idea." — John Locke

The communication of ideas to individuals and special groups of individuals is the principal objective of public relations. It is an activity which is sometimes referred to as the "engineering of consent."

Far too many people still regard public relations men solely as agents for the procuring of newspaper publicity, radio and television interviews. They measure a PR man's worth by type inches, bulk and weight of scrapbooks, and the number of radio and TV appointments, regardless of class of audience or air time.

What these persons fail to understand is that the gaining of attention is but one phase of public relations activity.

In addition to commanding attention by informing others of what you are doing, you may have need to convince them that their attitude toward you or your profession should be modified. Finally, your job is to integrate your attitudes and actions with those of the people with whom you deal.

We live in a competitive society of many interests. The interrelationships between the professions, business and industry, races and religions are among the many which seek a harmonious level.

It is wrong to assume that the mere mouthing of a policy of goodness is going to bring about a better understanding between you and your various publics,—i. e., patients, other physicians, legislators, and labor officials.

The policy of doing good must be established first and fulfilled. It is only then that public appreciation and understanding should be sought. Any other course of action soon becomes transparent.

It is the job of a public relations director to help define social objectives, learn where maladjustments exist, and offer advice on how policies and actions can best be spelled out for the public. He is most effective when he is included in the policy-making core of an organization, and his line of authority is clear and direct.

Quote unquote —

In his best-selling book, "The Organization Man," William H. Whyte Jr. makes the following observations on planning by committee:

"In a committee which must 'produce' something, the members must feel a strong impulse toward consensus. But if that something is to be a map of the unknown country, there can hardly be consensus on anything except the most obvious. Something really bold and imaginative is by its nature divisive, and the bigger the committee, the more people are likely to be offended.

"At this vital moment, the moral responsibility one feels to his colleagues becomes a

downright hindrance. A committee member might be inclined to support an idea, but he is also not inclined to put up the fight for it that will be needed. He is constrained by good will. He feels an obligation to his fellow committeemen, who are, after all, only trying to do a good job, like himself.

"So he compromises, not from mere timidity but from a real desire to show respect for the opinion of others. Even if he has trouble mustering up the respect in some cases, his good will may make him feign it. He has immediate social as well as professional considerations to think of, and throughout any meeting there runs a tacit dialogue that often has very little to do with the ideas being discussed.

"Who won the last argument? Is this wrangling going to shove us into a night meeting? We voted down Professor So-and-So the last two times; aren't we being a little hard on him?

"When the minutes get written up, this groping for consensus is left out, but the thin, gray residue is not."

Medical assistants

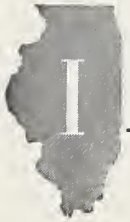
Medical assistants play an important role in our professional public relations. The manner in which they handle patients has a lot to do with forming the opinion of the public regarding medical care. In order to bring about a better understanding of the problems, the AMA has prepared and is distributing a packet of informative material for medical assistants. This may be obtained by writing to AMA headquarters, 535 North Dearborn Street, Chicago 10.

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Streptomycin and deafness

Most clinicians probably have heard of occasional patients who have suffered eighth nerve damage from only a short course of streptomycin, the dose not being excessive, and have been content to assume either an idiosyncrasy or an unrecognized impairment of renal function. That this is not a very rare occurrence and indeed, apparently is becoming more common is evident from the findings of Mr. T. Cawthorne and Mr. D. Ranger, at the National Hospital for Nervous Diseases. In the past six successive years, they have seen 22 patients who have suffered eighth nerve damage, affecting vestibular function in 21 and hearing in three, from total doses of streptomycin not exceeding 20 g. The total dose was 10 g. or less in 12 patients and in only seven was a daily dose of 1 g. exceeded. With one exception — a man of 25 with gross renal damage — they were middle-aged or elderly patients. This confirms the greater susceptibility of older persons but the paper also makes it clear that re-education to compensate for loss of vestibular function becomes increasingly difficult with age, a point being reached at which the permanent disability is very great. *Editorial. Toxicity of Streptomycin. Brit. M.J. June* 22, 1957.

AT THE EDITOR'S DESK



Squibb issued an unusual press release on their experimental cancer steroid, Broxoron. "Patients who have received treatment with this drug have talked about it, and exaggerated rumors have reached the press. For example, one excited lady has insisted that the editors of a leading weekly national magazine tell the world immediately about this new 'miracle cure for cancer.' Representatives of the press are now demanding an explanation."

In the circumstances, Squibb decided to abandon silence and present the facts to the press. The release says: "A new steroid named Broxoron (a halogenated progesterone derivative) has been tested on a limited number of patients with premenopausal metastatic cancer of the breast. Results, although not definitive, are adequate to warrant continuing control study. Obviously, a great deal of laboratory and clinical work remains to be done before conclusions can be drawn as to its carcinolytic value."

The Connaught Medical Research Laboratories, Toronto, has been working for two years on a quadruple vaccine against diphtheria, tetanus, whooping cough, and polio. They report considerable progress.

Upjohn reports that its new lotion (Neo-Cortef), containing neomycin and hydrocortisone, produced excellent to good results in 95 per cent of a group of 116 acne patients. There were no untoward effects after two to 24 months of use.

McNeil's new agent for the prophylactic management of angina pectoris is Pentrasine, a combination of pentaerythritol tetranitrate, butisol sodium, and reserpine.

Rep. Eugene J. Keogh (D., N.Y.) needs more support for his fight to get legislature favoring his voluntary pension plan for self-employed persons. The Treasury Department obviously is against it. It is difficult to understand the apathy on the part of physicians, who stand to benefit so much from a bill of this nature.

Hereafter, many women will be forced to tell their age on reaching their 62 birthday. Under the 1956 Amendments to the Social Security Act, women are able to obtain payments three years earlier than under the old law.

There is no end to the way the tax dollar is being used. More than 100,000 disabled workers have been notified that they have qualified for social security disability insurance benefits and will receive their first checks during August. To qualify for disability insurance benefits, a

person must be between 50 and 65 years of age and have a long lasting disability that prevents engaging in substantial activity.

From Europe, comes news of a new treatment of azoospermia with Tegotina, Activion (vitamin T complex). The sperm count increased in 12 of 14 patients and in three couples, pregnancy ensused after eight to nine years of sterility. What is vitamin T complex? Your editors are puzzled, too. It is reported to be an essential trace element for "soldier" termites and ants. It's possible this newcomer will be a competitor of the royal jelly of the queen bee.

W. H. Perloff, et al. reported that small doses of prednisone led to improvement of idiopathic hirsuitism.

The Travenol Artificial Kidney is now available to properly qualified clinicians at less than $1,200. These units are used in the treatment of acute renal insufficiency, transfusion reactions, postsurgical anuria, dialyzable poisons, chronic uremia, and malignant hypertension.

Preludin is the latest appetite suppressant. It is available only on prescription and the manufacturers claim it "works on the appetite center of the brain." They say their product "seems to make it easier to satisfy the appetite earlier in the meal without jitters or diet fatigue." This is a big order, if true.

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Bahamas medical conference

The fourth Bahamas Medical Conference, a post AMA. Clinical Meeting event, will be held at the Fort Montague Beach Hotel, Nassau, December 1-15.

More than 25 physicians will take part in the scientific presentations. Among those who will present papers are Dr. Edward E. Avery, thoracic surgeon, and Dr. Paul R. Rosenbluth, neurosurgeon, both of Chicago.

Special rates will be provided by the hotel. Dr. B. L. Frank, 1290 Pine Avenue West, Montreal, Que., is the organizing physician.

Steroids for orchitis

Four cases are presented of mumps orchitis treated by steroid therapy (Cortico-Depot, Nyco 100 I.U.). A rapid remission was noted in all cases, with a dramatic reduction in the local inflammation as well as generalized systemic effects. It is suggested that all cases of mumps orchitis be treated promptly with steroids, except in the presence of the usual unrelated contraindications to this form of therapy. *George W. Zeluff, M.D. and T. J. Fatherree, M.D. Steroid Therapy in Mumps Orchitis. Ann. Ind. Med. May* 1957.

NEWS of the STATE



ADAMS

Personal.—Dr. and Mrs. William Giles, Griggsville, have moved to Galesburg where Dr. Giles will be associated with Dr. Bernard W. Coan.

New Health Officer.—Dr. E. L. Sederlin, Helena, Montana, has been appointed director of the Adams County Department of Health, succeeding Dr. H. O. Collins who resigned in November, 1956, following twenty-five years of service.

Dr. Sederlin has had many years of experience in public health work. He served as director of the DuPage County Health Department for more than seven years before going to Montana as director of local health services for the Montana State Board of Health. His experience also includes four years as a health officer in the state of North Dakota, and four years in the state of Maryland.

For eighteen years, Dr. Sederlin engaged in the private practice of medicine, nine years in Cleveland, Ohio, and nine years in Laramie, Wyoming.

COLES

Community Hospital Dedicated.—On August 11 an open house featured the dedication ceremonies of the new fifty-two bed Charleston Community Memorial Hospital. Cecil H. Swedell is president of the board of directors of the hospital.

COOK

Physicians Elevated to Full Professorship.—Dr. Robert W. Wissler has been promoted to professor of pathology in the Division of Biological Sciences at the University of Chicago, and Dr. Albert Dorfman professor of pediatrics. Dr. Lowell T. Coggeshall, dean of the division, announced the appointments.

Dr. Calloway Organizes Medical Associates of Chicago.—The first established group of practice started by Negroes in Chicago with complete diagnostic facilities is now located in the Lake Meadows development. The group was organized by Dr. Nathaniel O. Calloway, a member of the staff at the University of Illinois College of Medicine, and consists of fourteen physicians and three dentists. The entire staff, including technicians, nurses and office personnel, numbers about forty persons. The new offices house a pharmacy, medical diagnostic and dental laboratories.

Personal.—Dr. Robert C. Stepto was recently elected president of the Cook County Physicians Association. He is chief of cytological research at Stritch School of Medicine of Loyola University where he is also an assistant professor of obstetrics and gynecology.—Dr. Herman N. Bundesen, health commissioner of Chicago, recently observed his seventy-fifth birthday.—Dr. Leon Unger has

returned to Chicago after giving eight presentations on bronchial asthma, migraine, and histaminic cephalgia. He spoke before the Medical Association and the Veterans Hospital in Puerto Rico; Bahama Medical Conference, Nassau; University of Miami School of Medicine; a joint meeting of the Florida Pediatric and Allergy Societies, Hollyood, Florida; and the Southwest Allergy Forum in Fort Worth, Texas.

Hospital News.—Ground breaking ceremonies were held recently for the construction of a three million dollar addition to Illinois Masonic hospital. The work, which will be completed by September, 1958, will increase the hospital's bed capacity from 400 to 600. Included will be an air conditioned eight story building with two basements, adjoining the present hospital in Nelson Street. This will provide for additions of several new departments and expansion of existing departments. Adjoining the hospital in Wellington Avenue will be a one story building with foundations designed to support seven stories eventually, newspapers reported.—The J. Emil Anderson diagnostic clinic, a million dollar addition to Swedish Covenant hospital, was dedicated with appropriate ceremonies July 14. The ceremonies also marked the fifty-first anniversary program of the Covenant Old Peoples home, located on the hospital grounds.

The Capps Prize.—The Institute of Medicine of Chicago is offering the annual Joseph A Capps Prize of $300 for the most meritorious investigation in medicine or in the specialties of medicine. The investigation may be also in the fundamental sciences, provided the work has definite bearing on some medical program. Competition for 1957 is open to graduates of Chicago medical schools who completed their internship or one year of laboratory work within a period of five years prior to January 1, 1957, excluding their terms of service in the Armed Forces. Manuscripts must be submitted to the Secretary of the Institute of Medicine of Chicago, 86 East Randolph Street, Chicago 1, not later than December 31, 1957. The manuscript of the prize paper, as submitted, is to become the property of the Institute of Medicine of Chicago. The prize winner may be invited by the Board of Governors of the Institute to present his paper at a meeting of the Institute. If no paper submitted is deemed worthy of the prize, the award may be withheld at the discretion of the Board of Governors. The prize was founded by Dr. and Mrs. Edwin R. Le Count.

The Holmes Memorial Lecture.—Dr. Irving H. Leopold, professor and chairman of the department of ophthalmology, Graduate School of Medicine, University of Pennsylvania, Philadelphia, recently delivered the third Edward Lorenzo Holmes Memorial Lecture of the Institute of Medicine of Chicago. His subject was "Therapy of Vascular Diseases of the Fundus". The presentation marked Dr. Leopold's selection of the Edward Lorenzo Holmes Citation and Award in recognition of his many contributions in the field of ophthalmology through research and through the training of ophthalmologists for careers in university teaching and research.

Specialty Society Elections.—Dr. Julius Bolgla was recently chosen president of the Chicago Society of Anesthesiology. Other officers are Drs. Bernard K. Galston, vice-president, and E. Trier Morch, secretary-treasurer.—At the June 24 meeting of the German Medical Society of Chicago, the following officers were elected: Ferdinand Seidler, president; Joseph R. Mueller, vice-president; Eugene F. Lutterbeck, secretary, and Edward V. Stalzer, treasurer. Named to the board of directors were Drs. Hans Deutsch, Joseph Gardy, Paul H. Holinger, Fidelius Knoepfler and Lydia Walkowiak.

Dr. Barth Named Professor—Dr. Jenkinson Retires.—Dr. Earl E. Barth, professor of radiology in the Northwestern University Medical School, has been named chairman of the department of radiology. The appointment is effective Sept. 1. He succeeds Dr. Edward L. Jenkinson, who is retiring as chairman of the department.

Dr. Barth, a graduate of Northwestern medical school, joined the faculty in 1931 as a fellow in radiology. In 1953 he was named

a full professor. He is also chief consultant in radiology at the Veterans Administration Research Hospital.

He is a past president of the Chicago Roentgen society and a past chairman of the executive council of the American Roentgen Ray Society. He also has served as treasurer and vice president of the American College of Radiology, and now is chairman of the Board of Chancellors of the College. He is a member of the Radiological Society of North America and a fellow of the Inter-American College of Radiology.

Dr. Jenkinson joined the medical school faculty in 1919 as an instructor in radiology. He has been professor and chairman of the department of radiology at Northwestern medical school since 1947.

During his years at Northwestern University he has become well known for his work on the x-ray diagnosis of gastrointestinal diseases. In 1954 he was chosen to deliver the annual Caldwell Lecture to the American Roentgen Ray Society, one of the greatest honors in the field of radiology.

Physicians Honored.—Dr. Charles B. Huggins, professor of urology and director of the Ben May laboratory for cancer research, University of Chicago, was recently presented with an honorary degree of doctor of science by Torino (Italy) university and elected honorary president of the Italian Urological Association, both in recognition of his contributions to research in the control of cancer by hormones.—At the annual meeting of the American College of Chest Physicians in New York recently, the following physicians from Chicago received their certificates of Fellowship in the College: Maurice Berger, Donald Cassels, Joseph R. Christian, Robert F. Dillon, Egbert H. Fell, Bessie L. Lendrum, Frederick M. Lindauer and Robert A. Miller. Otto L. Bettag was re-elected to the board of regents of the College.—Dr. Lowell T. Coggeshall, dean of the Division of Biological Sciences, University of Chicago, has been elected to the board of directors of the John Crerar Library.

The Hedblom Lecture.—Dr. Thomas G. Baffes, a member of the staff of Children's Memorial Hospital, recently delivered the Hedblom lecture at the University of Illinois College of Medicine. His subject was "A Surgical Correction for the Juxtaposition of the Great Vessels." The lectureship is sponsored by the Iota Chapter of Phi Beta Pi Fraternity in honor of the late Dr. Carl Hedblom, who, until his death, was professor of surgery and head of the department.

JEFFERSON

Tuberculosis Addition Dedicated.—Dedicatory ceremonies, August 18, marked the opening of a new addition to the Mount Vernon State Tuberculosis Sanitarium. Gov. William G. Stratton gave the principal address. Included among the speakers were Dr. Roland R. Cross, Springfield, Director of the Illinois State Department of Public Health. The sanitarium was established in 1951 with a bed capacity of 100.

GENERAL

Poison Control Centers.—Poison control centers are now located in Chicago, Springfield, Evanston, Peoria and Berwyn, according to the Illinois Health Messenger. Three additional centers are being planned for the downstate area. Each of the established centers offers facilities for emergency treatment of cases of poisoning. In addition, each center provides a twenty-four hour a day telephone service to answer inquiries from physicians regarding the ingredients of drugs and household supplies and to make recommendations as to the latest treatment methods.

Records of the numbers and types of cases of poisoning are maintained by the centers, which also serve as a focus for epidemiological studies and for research designed to evaluate various methods of prevention and treatment.

Cases of poisoning are reported by the centers to the State Department of Public Health. The centers also cooperate with the state and local health departments, and other official and voluntary agencies, in educational programs designed to prevent accidental poisoning.

To assist parents and others concerned with the prevention of accidental poisoning, the

U.S. Public Health Service has prepared a circular entitled Protect Your Family Against Poisoning. This informational guide gives a series of reminders regarding the handling and storage of drugs, poisons and other household chemicals. Copies of the circular are available to Illinois residents from the State Department of Public Health, State Office Building, Springfield.

Dr. Church Named Deputy Director.—Dr. Ruth E. Church has been appointed Deputy Director in charge of the Division of Hospitals and Chronic Illness of the Illinois State Department of Public Health, effective June 1. She succeeds Dr. G. Howard Gowen who resigned recently to accept a position with the International Cooperation Administration in Santiago, Chile.

Except for two years in the U.S. Army, Dr. Church has been associated with the department since 1945, first as director of the Fulton-McDonough County Defense Zone Health Department and later as health officer for District Health Department No. 3, with headquarters in Savanna. Since 1954 she has served as chief of the department's Bureau of Communicable Disease Control.

Prior to coming to Illinois, Dr. Church served for two years with the Wisconsin State Board of Health and for five years as director of a county health department in Iowa. She is also a graduate nurse and worked for three years with the Visiting Nurse Association in Chicago.

Postgraduate Medical Association.—The forty-second International Medical Assembly of the Postgraduate Medical Association of North America will be held at the Palmer House, Chicago, September 30-October 3, 1957, under the presidency of Dr. J. Mather Pfeiffenberger, Alton, Ill. Among the Chicago physicians on the program are William F. Mengert; Walter G. Maddock, Wayne B. Slaughter, James K. Stack, J. Peerman Nesselrod; Herbert E. Schmitz; Harry F. Dowling; Robert M. Kark; Warren H. Cole; M. David Allweiss, and M. Edward Davis. Included on the board of trustees of the association are Drs. Edwin S. Hamilton, Kankakee, and W. I. Lewis, Herrin.

New Award Announced at Voice Conference.—Dr. K. Faaborg-Andersen, Copenhagen, was recently selected as the first recipient of a new award for outstanding research in the field of laryngology; specifically Dr. Faaborg-Anderson was cited for his electro-myographic studies of internal laryngeal muscles in human beings. Presentation was made by Mr. W.E. Gould, president of the William and Harriet Gould Foundation, which made the award possible, during the International Voice Conference. The meeting dealt with laryngeal research, physiology and therapy in Thorne Hall on the campus of Northwestern University Medical School. It was under the joint chairmanship of Hans Von Leden, M.D., and Paul Moore, Ph.D., with the cooperation of representatives from all universities in the Chicago area. Delegates from twenty-five foreign countries and the United States represented all of the leading laryngeal research centers. The guest of honor, Dr. Eelco Huizinga, professor of otolaryngology, University of Groningen in the Netherlands, addressed the formal closing ceremonies on "The Larynx and Voice—Animals and Man."

DEATHS

Robert F. Lischer, Mascoutah who graduated at Washington University School of Medicine, St. Louis, in 1904, died July 6, aged 83. He was a member of the "Fifty Year Club" of the Illinois State Medical Society.

Samuel Franklin March*, Carrollton, who graduated at the University of Missouri School of Medicine in 1909, died April 28, aged 74, of bronchopneumonia. He had served on the board of health, the board of education and was a member of the staff of the Thomas H. Boyd Memorial Hospital.

Louis E. Schmidt, Wausau, Wisconsin, formerly of Chicago, who graduated at Northwestern University Medical School in 1896, died July 12, aged 88. He was emeritus professor of urology at Northwestern University Medical School.

*Indicates member of the Illinois State Medical Society.

Carl O. Schneider*, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1908, died July 18, aged 78. He limited his practice to opthalmology.

Abraham Morris Siegel, Chicago, who graduated at Northwestern University Medical School in 1913, died February 10, aged 70.

Anton Stockl*, Lansing, who graduated at The General Medical College, Chicago, in 1924, died April 27, aged 62, of acute coronary thrombosis. He was a member of the staff of St. Margaret Hospital, Hammond, and a member of the American Academy of General Practice.

Frederick O. Tonney*, Chicago, who graduated at Illinois Medical College in 1909, died July 11, aged 76. He was director of laboratories and research for the Chicago Health Department from 1909 to 1931, and assistant commissioner in charge of laboratories and research for the Health Department from 1931 to 1938. He served as medical officer for the Federal Trade Commission in Washington in 1939.

William B. Whitaker, Chicago, who graduated at Rush Medical College in 1897, died July 24, aged 82. He was house physician for the New Michigan Hotel for more than 50 years.

Sigmund S. Winton*, Chicago, who graduated at the University of Toronto Faculty of Medicine, Ontario, in 1939, died July 27, aged 45. He was an associate professor of medicine at Northwestern University Medical School and a member of the staffs of Columbus, Weiss and Oak Forest Hospitals.

*Indicates member of the Illinois State Medical Society

Treatment of arthritis of the hip

The treatment of degenerative arthritis of the hip usually can be conservative. Lessening of physical activities, use of a cane, and reduction of excess weight are all important. The various forms of salicylates are the most useful drugs. In acute phases, the intraarticular injection of hydrocortisone may be used. We feel the administration of an abundance of vitamins, particularly vitamins B, C, and E, is useful. Numerous surgical measures are available to lessen pain or deformity but none can be expected to give an entirely satisfactory result. These are major surgical procedures and should be carried out only on carefully selected patients. An arthrodesis of the hip is the one procedure that can be expected to give relief of pain but this is a formidable and difficult procedure to carry out in an elderly person. *J. Albert Key, M.D. and Lee T. Ford, M.D. The Treatment of Degenerative Arthritis of the Hip. Geriatrics. July* 1957.

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Infection in cancerous tissues

According to Lacassagne, infection of a cancerous lesion reduces the chances of cure. For example, infection in cancerous tissues is one of the well established contraindications to radiation therapy. Irradiation sensitivity of cancerous lesions is diminished in the presence of infection, and the surrounding inflamed tissues are increased in radiation sensitivity. Thus the irradiation sensitivity of cancerous and healthy environmental tissue becomes relatively equalized. The effectiveness of radiation treatment obviously is restricted because of this equalization. Necrosis may occur from irradiation in such instances as scirrhous cancer of the breast, sclerosing ulcer, or infiltrating carcinoma of the tongue. This occurs frequently in recurrent cancer after heavy irradiation. *Infections that Complicate Cancer. Cancer Bull. Nov.-Dec.* 1956.

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Retinal detachment

Treatment of retinal detachment requires early bed rest and surgery. Prognostically, Okamura and Schepens state that in cases of a retinal break with a minimum detachment, the probability of cure by operation is as high as 95 per cent. If the detachment is allowed to progress, this figure will drop to 50 or 60 per cent, owing to the formation of fixed folds in the retina plus vitreous retraction. Early cases with minimum detachment are treated chiefly by diathermic surgery. The more advanced cases are now treated by scleral buckling whereby the choroid is folded inward and brought into contact with the detached retina. Schaffer recently has introduced the idea of vitreous implatation whereby the detached retina is pushed back against the choroid and diathermy alone or with scleral buckling also is performed. *William H. Kratka, M.D. Diagnosis and Management of Ocular Problems. Delaware M.J. June* 1957.

. . . FOR EXAMPLE: In rheumatoid arthritis, "the first response" of patients treated with MARSILID "was a gradual increase in their generalized sense of well-being. Patients who formerly were depressed began to smile faintly, to show interest in their immediate surroundings, and presently to note an improvement in appetite. Many patients commented that they were beginning to feel as they had before they developed rheumatoid arthritis. Although joint pain and swelling were still present, these joint manifestations appeared to be tolerated better and were less a cause for concern. . . ."

Scherbel, A. L.: Cleveland Clinic Quarterly *24*:90 (April) 1957

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For complete references and information concerning dosage, indications, and contraindications, write V. D. Mattia, Jr., M.D., Director of Medical Information, Hoffmann-La Roche Inc., Nutley 10, N.J.

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BOOK REVIEWS



THERAPEUTIC EXERCISES FOR BODY ALIGNMENT & FUNCTION. By Marion William, Ph. D., Assistant Professor of Physical Therapy, Department of Allied Medical Sciences, School of Medicine, Stanford University, and Catherine Worthingham,, Ph. D., Director of Professional Education, The National Foundation for Infantile Paralysis, Inc. Exercise Illustrations by Harold Black. 127 pages. W. B. Saunders Company, Philadelphia and London. $3.50.

This book is timely and is put together in such form that its use should prove helpful.

The primary function of such a manual is dealing with problems of body alignment and function. The authors have accomplished this purpose well.

The text is well interspersed with drawing illustrations that are very interpretative.

Corrective exercises for defects or deformities, are explained in detail and efficiently, and after explaining the normal for that particular part of the body. The actual points necessary for the teaching of exercises are given proper space.This alone will appeal to all physical education teachers.

Chapter four portrays the principles of treatment and exercises for the various areas of the body. Chapter five deals with the positions of the body in activity and rest. And then the appendix deals with muscles very briefly.

The manual is well indexed and the bibliography is extensive.

C. P. B.

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MARTINS' GYNECOLOGICAL OPERATIONS. Translated and Edited by: Milton L. McCall & Karl A. Bolten. 7th Edition. Little, Brown & Co., Boston 6. Price $20.00.

This volume of 405 pages is presented in a slightly larger size than the usual standard text. It is beautifully bound and printed on quality paper. The illustrations and the visual aids of the operative procedures are logical, concise and informative.

One might take exception with certain of the procedures which are described. However, in a text of this kind various views must be expressed and thus it is necessary to include techniques even though the subject may be somewhat controversial. For instance, uterine suspension receives comparatively little endorsement by our specialty, but a moderate amount of space is given to these operations. The same comments apply to interposition operations. The illustrations of the procedures for treatment of the adnexa (52 pages) fall into the same situation. A number of operations are presented for various conditions of the cervix.

The index is abbreviated. To illustrate the brevity, it was difficult to find a reference to presacral neurectomy or "interposition opera-

(*Continued on page* 60)









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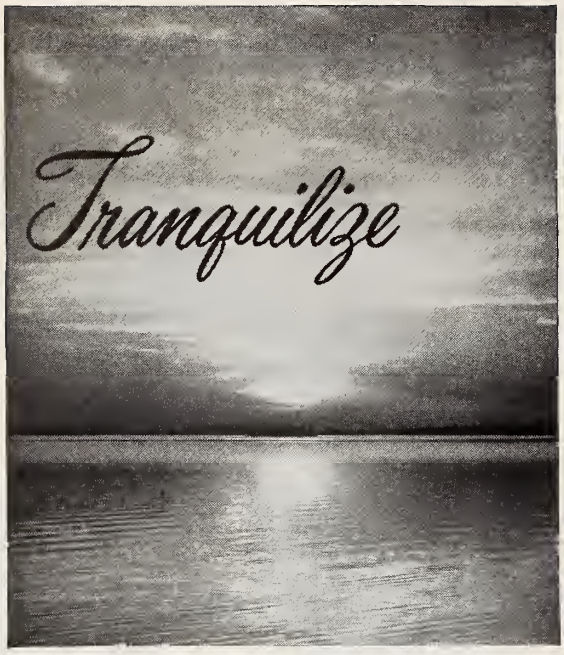
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BOOK REVIEWS (Continued)

tion", yet these are well presented by diagrams and illustrations.

The discussions continue throughout the volume in brevity and in places explanations are lacking. The limitations and risks pertaining to given procedures are inadequate. The illustrations for radical removal of the uterus and adnexa are very g o o d with ample emphasis upon the location of the ureters and the uterine vessels.

The above views on this volume do not prevent the high recommendation for a genecological surgical text. The special merit comes from the quality, number and sequence choice of illustrations and the inclusive variations of surgical procedures.

H. C. H.

‹ ›

THE MANAGEMENT OF FRACTURES, DISLOCATIONS AND SPRAINS. By John Albert Key, B. S., M. D., F. A. C. S., Clinical Professor Emeritus of Orthopaedic Surgery, Washington University School of Medicine, Associate Surgeon, Barnes, Children's and City Hospitals, St. Louis, Missouri; and H. Earle Conwell, M. D., F. A. C. S., Associate Professor of Orthopaedic Surgery, University of Alabama School of Medicine, Associate Orthopaedic Surgeon, University Hospital, Birmingham, Alabama. Sixth Edition. Pp 1,168, with 1,123 figures, 1956. The C. V. Mosby Co. St. Louis $20.00.

The preceding editions of this work have been good standbys for many practitioners. This new edition will uphold its predecessors reputation as a text book for the student or as a reference work for the busy practitioner.

This sixth edition is a bit reduced in size compared with former editions. However, nothing has been deleted that is not in line with the recent accomplishments of surgeons throughout the whole wide world. No words are wasted on obsolete practices. Much material has been added delineating new ideas, as in intramedulary nailing and in injuries of the spine, in hand fractures, etc.

The illustrations, photographs and reproductions of X-ray films presented are well chosen and certainly clarify the problems being pre-

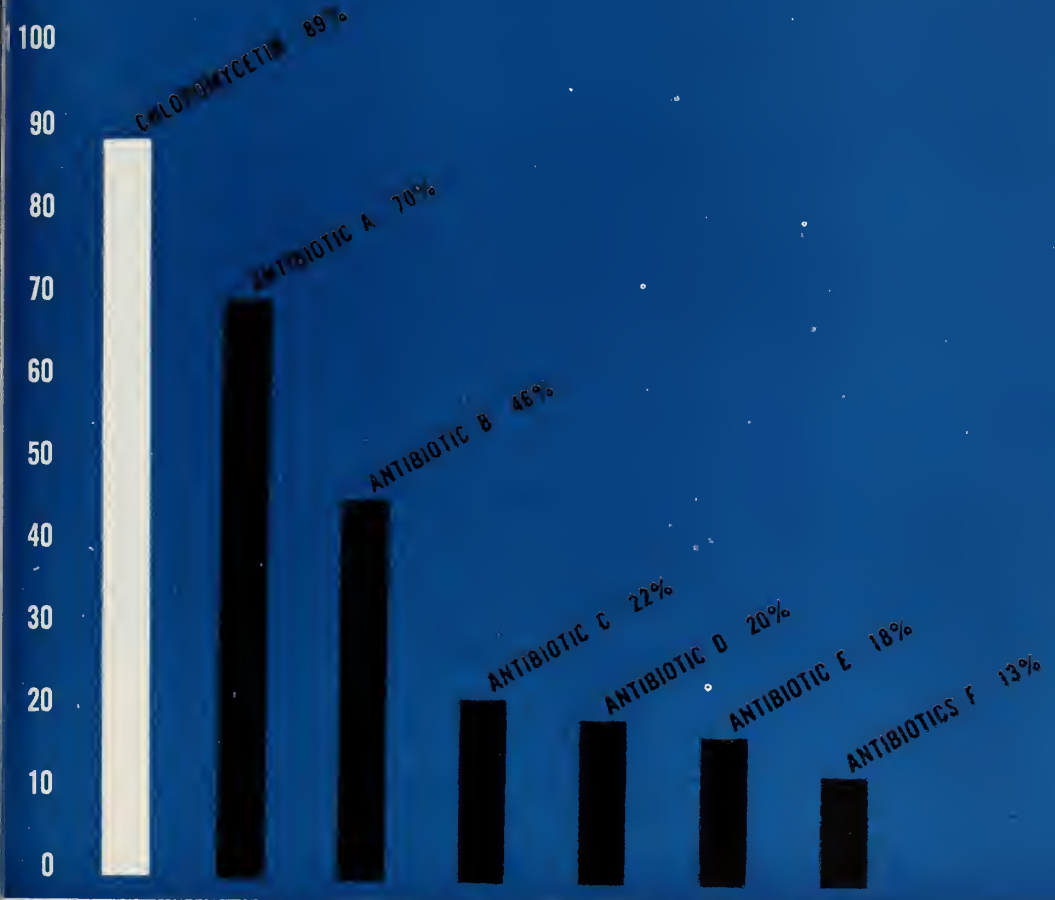
(*Continued on page* 62)

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BOOK REVIEWS (Continued)

sented. The index is adequate enabling rapid reference finding.

The authors are to be congratulated for this production. This famous book will add to the stature of the authors.

C. P. B.

‹ ›

A FRONTAL SECTION ANATOMY OF THE HEAD AND NECK. Otto Kampmeier, Ph. D., M. D., Arthur R. Cooper, Ph.D., M. D., Thomas S. Jones, B. F. A. University of Illinois Press, Urbana, Ill. — $15.00.

This is a very unusual book — an atlas; a frontal section of the anatomy of the head and neck, a remarkable production. It is unlike any work heretofore produced.

In their introduction the authors recite the occurrence of sections from all publications available up to the present time. They describe many of them and assert their value as references and also explain how the original sections were made. They became convinced that sections in the frontal plane, because of their bilateral vertical orientation showing the longitudinal continuity of many structures would add greatly to the dissector's insight or review of their relationships. They could find nowhere any complete consecutive series of such sections published.

The authors conceived the plan of making consecutive sections, longitudinally of the head and neck, spacing the sections at 2 cm. distance from the front to the back. These were mounted in museum jars. A bit later the work was made even more valuable and more detailed by sectioning each of these mountings into two sections. Thus was accomplished the twenty consecutive sections making up this atlas.

At the outset of this atlas there are five drawings which are greatly helpful to the understanding of the actual pictorial reproductions of the twenty sections. These drawings show the planes of the sectioning and also one the relationship of the large arteries and another the relationship of the larger veins.

The sections are shown at "almost exactly the same plane from side to side." The photographs are of the anterior surface of each sec-

(*Continued on page 66*)





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BOOK REVIEWS (Continued)

tion and they are actual life size. They are not colored. The labeling is very extensive indeed and yet the lines or dots from the label to the "structure" are very unobstrusive and do not detract from the actual photograph. A truly commendable feature and one for which the printer is to be commended.

The atlas is not a work primarily for students, but is valuable for reference. Five reconstructive drawings and twenty plates.

C. P. B.

‹ ›

AN ATLAS OF ANATOMY by J. C. Boileau Grant, M. C., M. B., Ch. B., F. R. C. S. (Edin) Professor of Anatomy in the University of Toronto. By regions, Upper Limb, Vertebrae, Vertebral Column, Thorax, Head and Neck, Cranial Nerves and Dermatomes. Fourth Edition. The Williams and Wilkins Company. — Baltimore $15.00.

As were the previous editions this book is a wonderful anatomical atlas with added new illustrations and many improved or replaced illustrations.

The illustrations present structures of the human body region by region. They are prepared from actual dissections and are as authentically true as is humanly possible. The text accompanying the illustrations is interpretative, and directs attention to important points that may be otherwise overlooked. And for depicting accurate and detailed information as to relative position of various arteries, or nerves, or muscles, or bones, etc., the color almost presents a third dimension view.

The use of color in a great number of the plates certainly adds clarity to the definition of the component structures illustrated.

This work is indeed a great visual aid to one's study or review of anatomy. It can be recommended without reserve to the student and to the practicing physician; and deserves a plaee in every progressive physician's library.

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1. McHardy, G. and Browne, D.: South. M. J. 45:1139, 1952. 2. Hufford, A. R.: Rev. Gastroenterol. 18:588, 1951. 3. Johnston, R. L.: J. Indiana M. A. 46:869, 1953. 4. Miller, B. N.: J. South Carolina M. A. 48:245, 1952.

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BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

An Atlas of the Commoner Skin Diseases. With 153 plates reproduced by direct color photography from the living subject. By Henry C. G. Semon, M. A., D. M. Oxon., F.R.C.P., London. Revised with the collaboration of Harold T. H. Wilson, M.A., M.D. Cantab., M.R.C.P., D.T.M. Color photography originally directed by the late Arnold Moritz, B.A., M.B., B.C. Cantab. Fifth edition. The Williams and Wilkins Company, Baltimore 1957. $20.00.

Surgeons All. By Harvey Graham, M.D. Foreword by Oliver St. John Gogarty. Philosophical Library, New York. 29 illustrations. $10.00.

Psychiatry in Theory and Practice. By Beulah Chamberlain Bosselman, M.D., Professor of Psychiatry, College of Medicine, University of Illinois, Chicago, Illinois. Charles C. Thomas, Publisher, Springfield, Illinois. $4.00.

The Ordeal of Gilbert Pinfold. A conversation piece. By Evelyn Waugh. Little, Brown and Company, Boston and Toronto. $3.75.

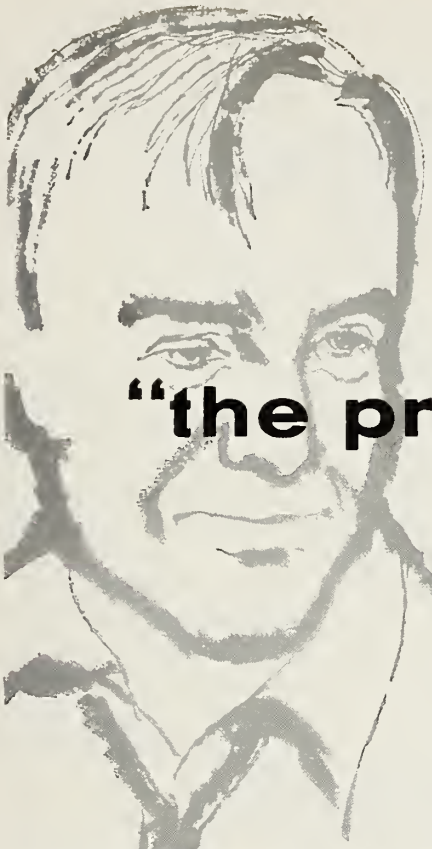
Science Looks at Smoking. A new inquiry into the effects of smoking on your health. By Eric Northrup. Introduction by Dr. Harry S. N. Greene, Chairman, Department of Pathology, Yale University. Coward-McCann, Inc., New York, $3.00.

Kaposi's Sarcoma. Multiple Idiopathic Hemorrhagic Sarcoma. By Samuel M. Bluefarb, B.S., M.D., F.A.C.P., Associate professor of Dermatology, Northwestern University Medical School, Attending Dermatologist and Chairman, Department of Dermatology, Cook County Hospital, Attending dermatologist, Veterans Administration Research Hospital, Assistant Attending Staff, Chicago Wesley Memorial Hospital, Chicago, Illinois. Charles C. Thomas, Publisher, Springfield, Illinois. $5.50.

The Salient Points and the Value of Venous Angiocardiography in the Diagnosis of the Cyanotic Types of Congenital Malformations of the Heart. By Benjamin M. Gasul, M.D., Gershon Hait, M.D. Robert F. Dillon, M.D., Egbert H. Fell, M.D. A 10 year study of 421 angiocardiograms done on 283 patients. Charles C. Thomas, Publisher, Springfield, Illinois. $3.50.

Dermatologic Formulary. From the New York Skin and Cancer Unit, Service of Dermatology. (Dr. Marion B. Sulzberger, Director) Frances Pascher, M.D., Editor, Revised, 1957. A Hoeber-Harper Book. $4.00.

Ciba Foundation Colloquia on Ageing. Volume 3. Methodology of the Study of Ageing. Editors for the Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., B. Ch. and Cecilia M. O'Connor, B. Sc. 47 illustrations. Little, Brown and Company, Boston, $6.50.



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The spirit of rest

Restlessness may be described as overmobilization of energy — having more energy on the very verge of expression than the job at hand can possibly use and often more than can be demobilized automatically within the time limits of an ordinary night's rest. The effect of such overmobilization is that the periods which should be given to rest are largely occupied with unsuccessful attempts to demobilize this accumulation of unexpressed energy. The result is a nocturnal state of uncomfortable tossing and futile effort so familiar to the insomniac. The spirit of rest is acceptance whereas intolerance and anxiety are its arch enemies. Without the realization that failure and frustration are as necessary and valuable experiences as are success or victory, there can be no contentment, no peace of mind, and no real rest. There is always some failure in success and some success in failure. These problems cannot all be cleared away at the end of each day. How then can one ever rest? Only by considering all things past, up to and including the present moment, as finished, by accepting the point of departure for tomorrow's efforts, and by considering the role we find ourselves playing today the result of the irrevocable past: "The past is a dream, the future a vision, the present a reality." And in this case, the present is the opportunity to r e s t. *Robert B. McGraw, M.D. Disorders of Sleep. New York J. Med. May* 15, 1957.

‹ ›

Low fat diet

If for no other reason than the avoidance of obesity, there probably will be a trend in this country to less rich diets which generally means less fat in the diet. Another reason deals with atherosclerosis and its complications, particularly coronary artery disease. This is where we run into the relative merits of saturated versus unsaturated fats. This is an active field of current research and one where a statement made today may be shown to be wrong tomorrow, and both statements may very well come from our own laboratories. *Frederick J. Stare, M.D. Recommendations Regarding Fat in the Diet. Food Processing, July* 1957.

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About 450 physicians complete their training in psychiatry each year. Another estimated 100 physicians take jobs in mental hospitals and become psychiatrists through experience rather than through formal training. If 550 are added each year, about 100 die or retire from practice; so the net gain is approximately 450 each year. It is possible that more will enter psychiatry as training and professional satisfactions in the field increase. But at the present rate it will take 20 years to double our present number and that is a conservative estimate of how many are needed right now. Moreover, it is estimated that our population will increase to around 225 million by 1975, so our projected gain is even less impressive. To complicate the matter further, there is urgent need for psychiatrists in certain special categories. This includes child psychiatrists of whom, I am told, 40 are trained each year. It includes those who are equipped to become administrators of state programs, superintendents of hospitals, and general practitioners in psychiatry—who are more sought after than gold by other physicians — social psychiatrists, and others interested in and capable of leadership in community programs, industrial psychiatry, and court psychiatry. Our current rate of increase means that one new psychiatrist is added yearly for every 350,000 people in the United States. *Daniel Blain, M.D. and Robert L. Robinson, M.A. Personnel Shortages in Psychiatric Services. New York J. Med. Jan.* 15, 1957.

‹ ›

What is motherliness?

Helene Deutsch comes close to a concise psychological definition of motherliness. She describes it as a delicate balance or harmonious interplay between narcissistic tendencies and masochistic readiness for painful giving and loving. Stated more simply, and I hope without losing its validity, we can say motherliness is a balance between the woman's need to be loved and her capacity to give love in an altruistic sense. This concept of motherliness is, according to Deutsch, characteristic of the truly feminine woman. *James E. Simmons, M.D. Why People Want to Adopt Children. J. Indiana M.A. Sept.* 1956.

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1. Dickel, H. A., Wood, J. A. and Dixon, H. H.: Electromyographic studies on meprobamate and the working, anxious patient. Ann. New York Acad. Sc. **67**:780, May 9, 1957.

2. Dickel, H. A., Dixon, H. H., Wood, J. A. and Shanklin, J. G.: Electromyographic studies on patients treated with meprobamate. West. J. Surg. **64**:197, April 1956.

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Letters to the editor

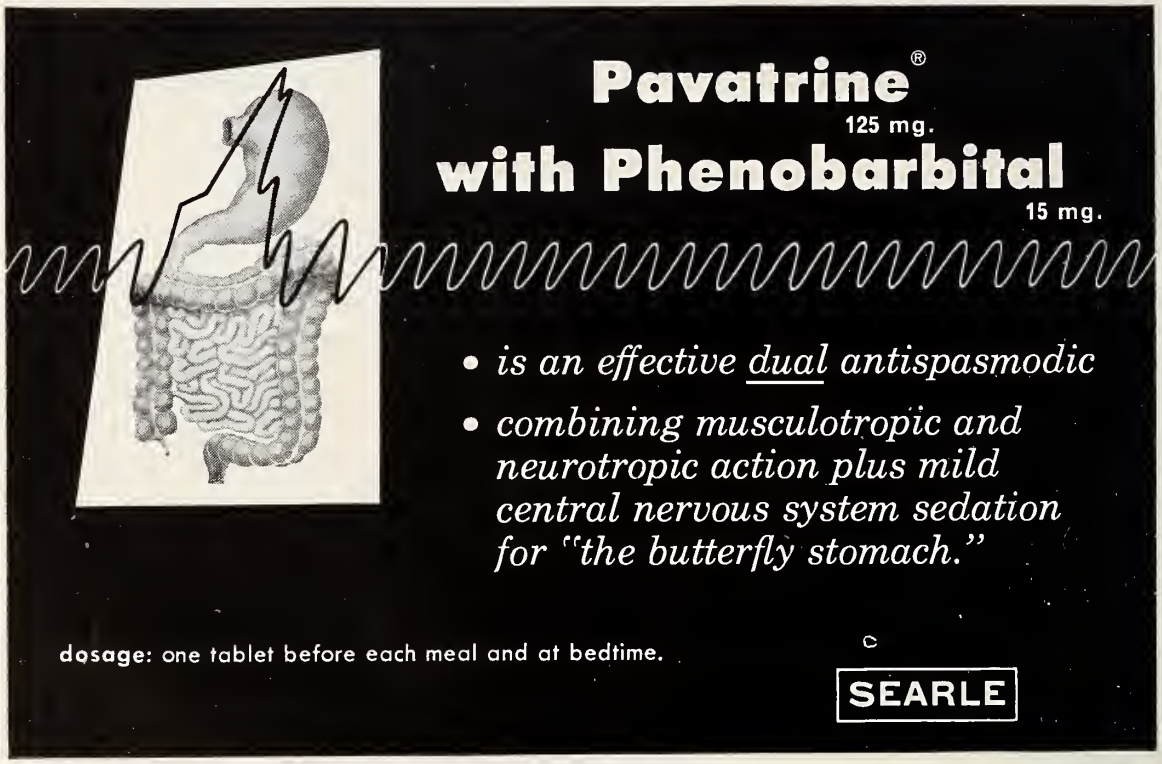
Though my researehes are not exhaustive, I have so far seen only two medieal journals in whieh a substantial bulk of the reading matter eonsists of letters to the editor. They are both weeklies published in London. Why, one wonders, do so few doctors in the United States think it worth while writing to the J.A.M.A. and are there really no amused or angry Swedes to write to Svensk kem. Tidskr.? Yet woe betide the man who makes a rash remark in his letter to a London editor. By return air mail post eomes an admonitory letter from Minneapolis or Madagascar: "It appears to have escaped the notiee of Dr. X, in his otherwise admirable paper, that I first pointed out the use of seaweed in psoriasis as long ago as . . ." But one must admit that there is a eertain gratifieation that someone in Puerto Rieo or Pennsylvania is suffieiently interested to question the validity of one's statements. But perhaps the most pleasing feature of the London correspondence columns is the hospitality offered to the most unexpeeted of esoteric subjeets. Where else, to quote a reeent example, eould one expeet to read a diseussion on the utility of the word foex? We may rest assured that so long as the eatholie nature of the correspondenee eolumns is thus maintained, so long will London remain the commodious seat of learning that it is today. *In England Now. Lancet, June* 1, 1957.

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in spasticity of the GI tract

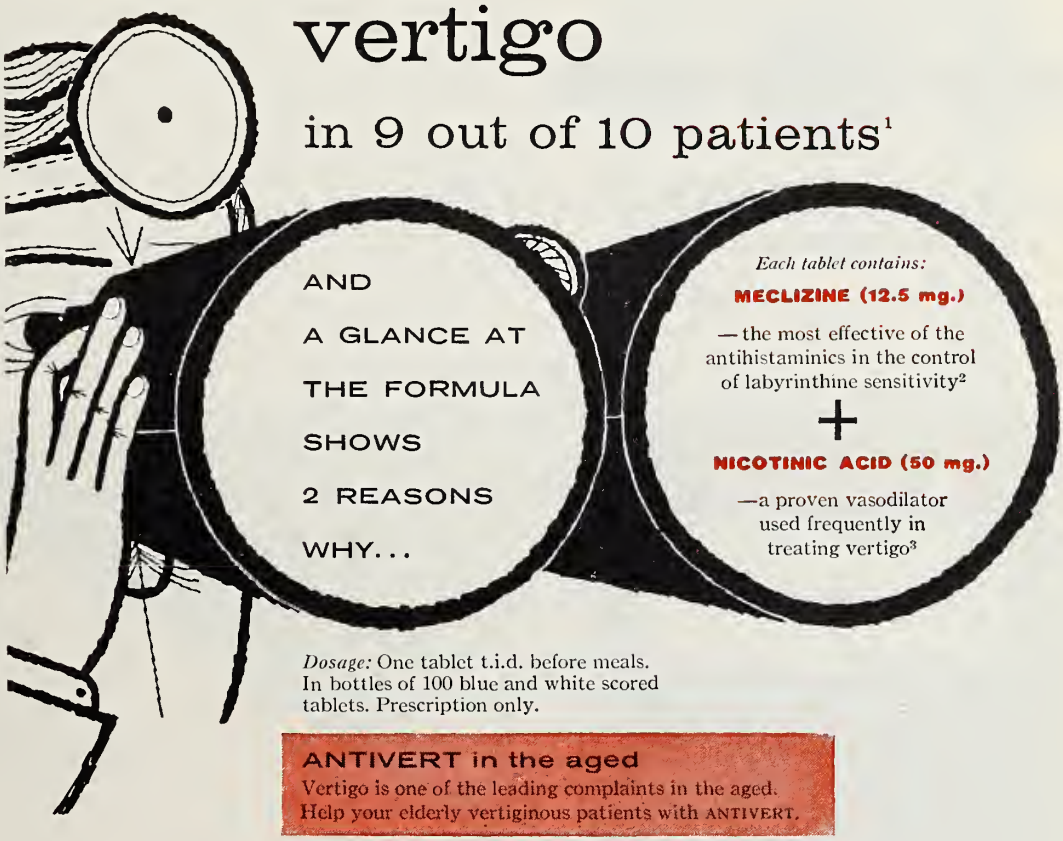


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References: 1. Menger, H.C.: Clin. Med. *4*:313 (March) 1957. 2. Charles, C.M.: Geriatrics *2*:110 (March) 1956. 3. Shuster, B.H.: Med. Clin. of N. Amer. *40*:1787 (Nov.) 1956.

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Why they leave general practice

Recently it was brought to my attention that a number of men were leaving general practice to return to residencies in the various specialties, not always because of an inner drive to know one subject well rather than know many subjects from a pragmatic point of view, but because of interpersonal professional problems with specialists. It was stated that they are hurt, annoyed, and embarrassed by being made to feel inferior, by the usurping of patients by specialists, and by the direct or indirect restriction of the pleasurable challenges in medicine. They sometimes are made to feel like moronic purveyors of fascinating cases to their more gloriously endowed colleagues. For this they get little consideration, and brief, late, or no reports at all, and perhaps a fleeting glimpse of their former loyal patient as he or she passes in review through the halls of the specialists. This condemnation of the specialist, and reason for leaving general practice bears consideration of the relationship between the consultant and the attending physician, the relationship between the specialist and the family medical advisor. *A. D. Dennison, Jr., M.D., To Each His Own Dignity, J. Indiana M.A. March,* 1957.

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Medicine in Norway

There appears to be a remarkably happy relationship between the medical profession and the administration of the insurance scheme. The Norwegian doctor is a highly respected person in Norwegian society, and enjoys on the whole a better income than other professional men. There is, if anything, a shortage of doctors, and the number of new students admitted each year to the university is limited. Norway has managed to combine compulsory health insurance with maximum freedom for the doctor to pursue his own career in a system which brings out a maximum sense of responsibility in both physician and patient. There seems to be peculiarly little abuse of the method of paying the general practitioner by fee for items of service, and an efficient machinery for dealing with abuse when it occurs. We have much to learn from our northern forebears. *Editorial. Medical Services in Norway. Brit. M.J. May* 11, 1957.



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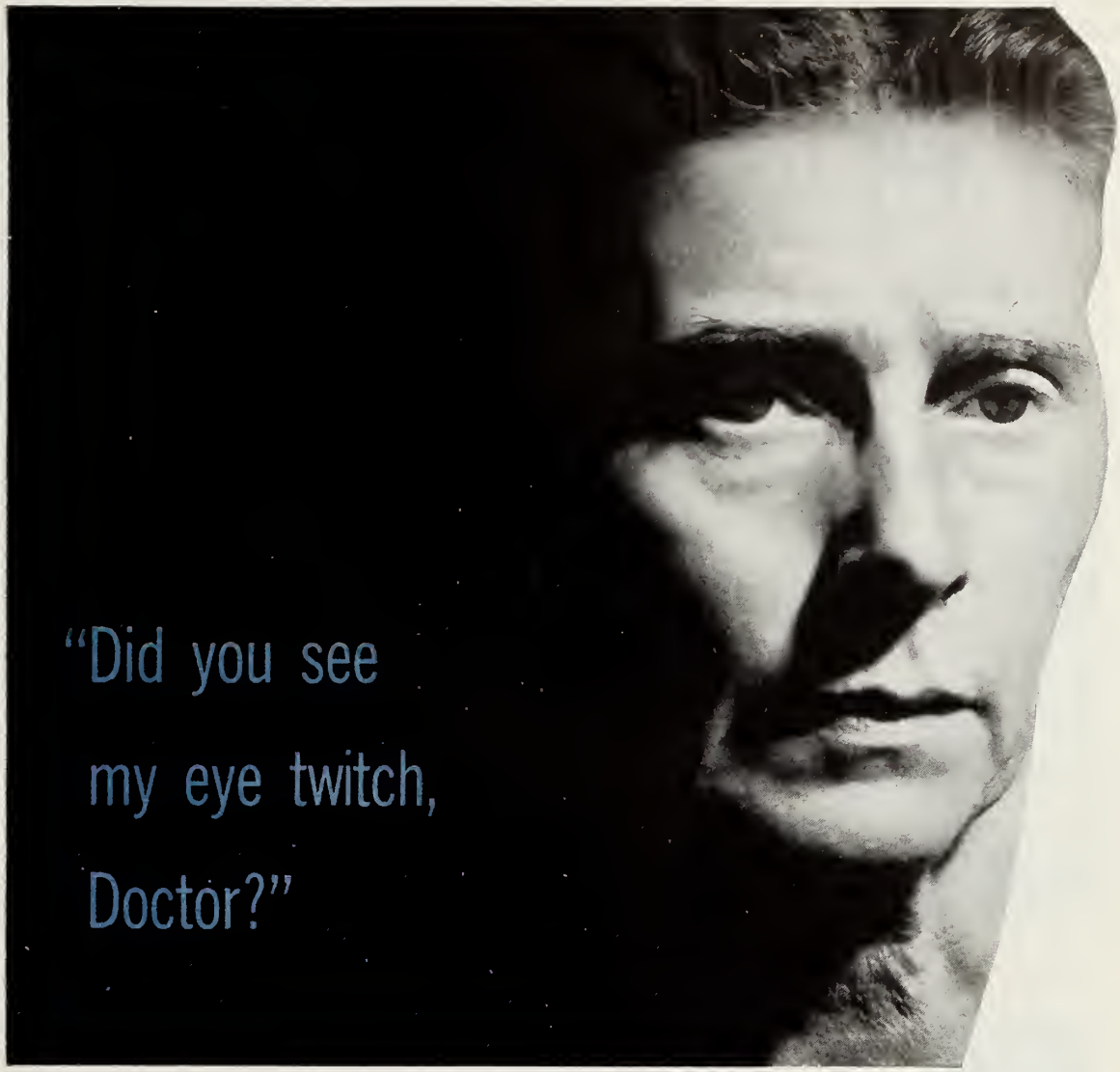
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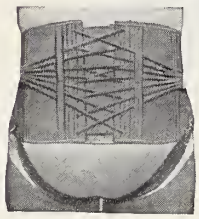
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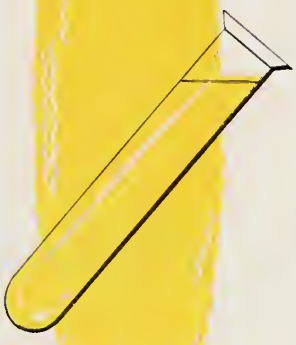
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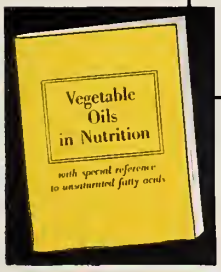
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	Ave.	Range	Ave.	Range	Ave.	Range	Ave.	Range	Ave.	Average	Range
Butter	—	46-48	—	—	4.0	—	1.2	—	0.2	—	26-42
Coconut oil	—	75-88	—	5-8	—	1.0-2.5	—	—	—	—	7-10
Corn oil	13	11-15	—	23-40	56	46-66	—	0.0-0.6	—	126	113-131
Cottonseed oil	26	21-30	27	22-36	47	34-57	—	—	—	105	90-117
Lard	43	—	46	—	10	15.6	0.5	—	0.5 (2.1)	—	53-77
Linseed oil	—	6-12	—	13-31	—	10-27	—	30-64	—	—	170-204
Margarine	23	15-23	62	59-77	5.8	5-11	—	0.1-0.9	0	81	74-85
Olive oil	—	8-16	—	53-86	—	4-20	—	—	—	—	80-88
Peanut oil	17	14-22	54	44-65	29	20-37	—	—	—	98	90-102
Shortening	25	17-45	62	43-79	5	3-12	—	0.2-0.6	0-0.5	78	59-80
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The Month in Washington

Washington, D. C. — In the last few years interest has built up in the problems of the older people—how they are to get their bills paid, how to spend their time constructively, what chronic medieal conditions are causing them the most trouble. Innumerable national and local conferences have searched for ways to make life more satisfying and healthy for people entering old age, and committees are at work on the problem in thousands of communities.

In this favorable climate, when every device that might help the older citizens is being examined, there is being revived a scheme that met with no success at all when first proposed more than six years ago.

It is a plan for government-paid hospitalization under the Old Age and Survivors' Insurance system.

Here is the argument that is made for it:

People in old age generally have less income than when they were younger, but at the same time they require more medical attention and hospital care. Neither voluntary nor commercial health insurance has been able to offer these people the protection they need. The only solution, sponsors of the plan say, is to get the federal government into the picture.

Opponents of the idea agree that older people are sick more often and generally don't have much money, but they disagree violently with the other arguments. They point out that slowly but surely insurance coverage is being extended to older people at a price they can afford to pay. Most important, hospitalization-at-65 critics maintain that a system like this is in effect national compulsory health insurance under Social Security.

Early this year Reps. Emanuel Celler (D., N. Y.) and John Dingell (D., Mich.) introdueed bills on this subject. They would allow 60 days a year free hospitalization for OASI-covered men 65 and over and women 62 and over. Rep. Kenneth A. Roberts (D., Ala.) offered a similar bill.

Just before the session ended two developments occurred that are evidence the proponents of this system of hospitalization are getting ready to make a real fight for it next year.

First, Rep. Aime J. Forand (D., R. I.) presented a bill that would make extensive liberalizations in the social security program, including creation of a hospitalization plan that would give free surgical service to the aged. Some national labor leaders immediately pledged their support to this bill, a not unexpected move as the AFL-CIO is officially behind the general idea.

Then Senator Richard L. Neuberger (D., Oregon) made it plain he, too, wanted the old people to have free in-hospital medical care. The senator said he hadn't firmed up his thoughts, but that he believed the best approach would be something like the Military Dependent Medical Care program (Medicare), making use of Blue Cross or other nonprofit groups. He estimates that a 1% increase in payroll taxes for both employer and employee would meet the extra costs.

Mr. Forand, on the other hand, is specific. He would make all persons receiving OASI retirement benefits eligible and also surviving widows and children, but would not include persons re-

(*Continued on page* 34)

2 NEW CONVENIENT ORAL FORMS

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ceiving OASI disability payments. He would broaden the time period by allowing 120 days of hospital or nursing home care each year, with hospital stays limited to 60 days.

The Forand measure also has a provision, not contained in most earlier bills, for OASI also to pay for in-hospital surgical services certified as necessary by the physician.

Mr. Forand would take no chance of running out of money. He would levy social security payroll taxes on all income up to $6,000 (present limit $4,200), and also increase the tax rate a half per cent for employer and employee alike, and three-quarters of one per cent for the self-employed.

It is almost certain that these and other similar suggestions will receive serious consideration by Congress next year, with passage of a bill much more likely than in 1951 when President Truman and Oscar Ewing first proposed the idea.

NOTES

When Congress returns January 7, one of the measures waiting its attention will be a bill to control union welfare funds through registration and publicity. (Most funds involve medical-hospital benefits.)

Jenkins-Keogh legislation, for deferment of income taxes on money put into retirement plans by the self-employed, now is assured of a hearing next year when the House Ways and Means Committee goes into all phases of taxation.

The Atomic Energy Commission has made its 100,000th shipment of radioisotopes, many of them for medical use.

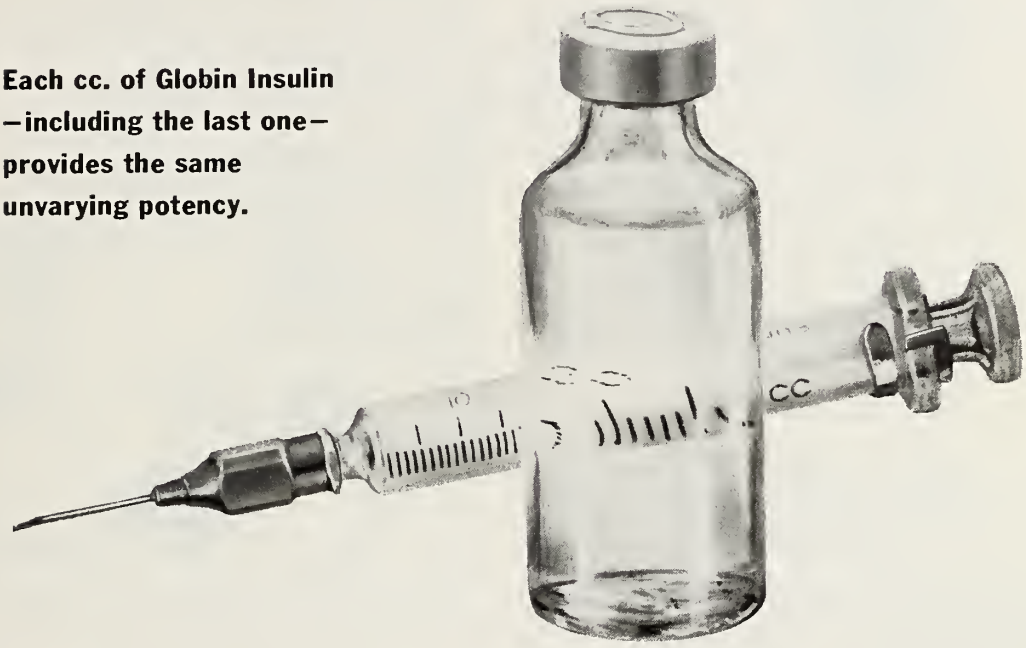
The National Heart Institute, Bethesda 14, Md., has a new booklet, written in popular language, on cerebral vascular diseases.

American Medical Association is co-operating with American Hospital Association in an effort to persuade the Federal Communications Commission to set aside radio channels for exclusive use of doctors and hospitals.



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Memories of Chicago Internists

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TIME blunts all memories. Some 45 years have passed since I graduated from Rush Medical College. When I accepted the assignment to speak on this subject, memories poured upon me. Perhaps I remember more about the surgeons who seemed more dramatic, the pathologists with whom I worked more intimately, the politicians who were more annoying. But as I have analyzed more deeply I have come to the conclusion that Frank Billings towered so mightily above all others in my environment that he occupies the major portion of my reminiscences. After all I didn't think of him as an internist—only as a stupendous man!

In the early 1900's when I came to Chicago to attend the university, Billings, Herrick, Sippy, Quine, Mix, Preble, Tieken, Slaymaker, Miller, Irons, Capps, Bloch, and a good many others were internists. A few special societies had been organized. The first was the Association of American Physicians in 1886. The American Gastroenterological Association was organized in 1897 and the American Proctologic Society in 1899. The deluge began shortly after the beginning of the 1900's with the American Society for Clinical Investigation in 1908, the American Association of Clinical Research in 1909. Then came the American College of Physicians in 1915. In those early days an internist acquired status by his special talents in diagnosis, treatment, and bedside manner. The American Board of Internal Medicine was established in 1936. Today the Simonpure article is inspected, surveyed, accredited, and suitably stamped with the insignia that testify to his competence.

My first contacts with reputable internists of the Chicago area came shortly after 1910 when I became associated with Dr. Ludvig Hektoen in his office as an assistant. My duties consisted of polishing golf clubs, helping with the correspondence, helping to edit the *Journal of Infectious Diseases* and the Fenger memorial volumes, coming back late at night to see the results of the various tests (precipitins and agglutinins), doing some occasional postmortems, and other duties that came readily to hand. I arrived early in the morning and while sitting an hour or more with Dr. Hektoen would enjoy the occasional visits particularly of Drs. Frank Billings, James B. Herrick, and Walter Haines. These conversations dealt with a great variety of topics from ancient and modern literature to scientific observations and current medical politics.

FRANK BILLINGS

The personality, incisiveness, and position in medical affairs of Frank Billings made him a veritable colossus of medicine in Chicago. I was soon to find that he was no less a great figure in all the medical world.

Read before the Chicago Society of Internal Medicine, May 27, 1957

When the American Medical Association met in 1899 Dr. Billings was chairman of the Section on Medicine. There were 83 papers and he had secured 54 abstracts. He made the suggestion that a rule be adopted requiring every member who wished to prepare and present a paper at any future meeting to prepare and send to the official of the section a short synopsis of the paper to be presented in advance of the meeting. He also suggested a standard for papers—namely, that they should concern original research. He recognized, however, the value of full reports of cases if supported by postmortem examination.

For many years various groups in the American Medical Association had been trying to build a monument to honor Benjamin Rush. Dr. Billings became head of the committee to raise money for the Rush monument which under his leadership assembled more than $15,000.

At the meeting of the American Medical Association in 1902 Dr. Billings was elected president. From that time on he was one of the most important officials in building the American Medical Association. One of his most significant tasks was the reconciling of the two medical societies in the state of New York which finally brought New York into the American Medical Association.

At the meeting of the American Medical Association in 1903 Dr. Billings' presidential address dealt with medical education in the United States. This address and even more significantly his address to the House of Delegates were vital to the progress of medicine in this country. He advocated complete reorganization of the four-year graded medical curriculum with preacademic training and one year of approved hospital internship. He further advocated that professors of basic sciences be placed on full-time and that as soon as possible the heads of the clinical departments be filled by professors on full-time. These recommendations led to the establishment of the Committee on Medical Education. He was a member of that committee in 1903-04. Under his leadership no doubt, Dr. Arthur Dean Bevan as chairman of the Committee made a report which included a recommendation that a committee on education be established with a full-time salaried assistant secretary and with headquarters in the office of the American Medical Association. This was the origin of the Council on Medical Education and Hospitals.

A testimonial banquet was tendered to N.S. Davis, founder of the American Medical Association, in 1901. The banquet was attended by 350 physicians from all parts of the country. Dr. Davis sat between Christian Fenger, who was toastmaster, and Dr. Billings. I have been unable to find any picture taken at that banquet. I wish there had been a tape recorder.

At that time the American Medical Association had 9,000 members out of 100,000 physicians in the United States. Today it has 136,000 members out of 220,000 physicians.

In 1903 a proposal had been made that the Northern Trust Company act as treasurer of the American Medical Association. The House of Delegates disagreed and Dr. Billings, former president, was nominated as treasurer. As such he sat with the Board of Trustees for many years thereafter. His influence, his wisdom, and his efforts were great assets to the American Medical Association during its development period.

When the campaign for cleaning up medical education began, Dr. Billings brought into the American Medical Association as the first secretary of the Council on Medical Education Dr. Nathan P. Colwell. Dr. Colwell traveled about with Abraham Flexner inspecting the medical colleges. The support of the Flexner findings and the respect of Mr. Flexner by such people as Frank Billings and N.P. Colwell were no doubt the important factors in the significance of the Flexner report.

Flexner tells in his autobiography that Dr. Pritchett of the Carnegie Foundation had been in touch with the Council on Medical Education of the American Medical Association and asked whether it might not be wise for Mr. Flexner to have an advisory committee of physicians to study the subject. Mr. Flexner suggested that the decision be postponed. He then went to Chicago to confer on the general situation in medical education with Dr. George H. Simmons and to review the reports prepared by the Council on Medical Education by Dr. N.P. Colwell. He said, "Colwell's reports were creditable and painstaking documents which, as Dr. Pritchett foresaw, had to be extremely diplomatic because the faculties of which consisted of their fellow

companions. Dr. Colwell and I made many trips together but, whereas he was under the necessity of proceeding cautiously and tactfully, I was fortunately in position to tell the truth with utmost frankness."

The American Medical Association had begun its campaign to raise the standards of medical education before Mr. Flexner got into the field. Dr. Colwell had traveled with Mr. Flexner in making his inspections and the Flexner reports were prepared with the advice and counsel of Dr. Colwell. Mr. Flexner eventually became well nigh possessed by the concept that only a medical school with a full-time faculty could properly teach medicine. When he made his original report he wrote in April 1909 from Chicago that 12 of the 15 medical schools in Chicago will close the moment the laws are enforced and he noted that "we were threatened with law suits and in one instance actually sued for libel for $150,000. I received anonymous letters warning me that I should (*sic*) be shot if I show myself in Chicago, whereupon I went there to make a speech before the meeting of the Council on Medical Education and returned undamaged."

At that time Drs. Frank Billings and Arthur Dean Bevan as representatives of the American Medical Association were involved in two suits brought against the Association by medical colleges which found themselves suddenly without students or repute before the Medical Board of Examiners. Those who filed the suits had nothing to gain and withdrew the suits. The schools died soon after.

In 1903 Dr. Billings called the attention of the House of Delegates of the American Medical Association to the need of a National Council of Pharmacy and urged the formation of a federal bureau of foods and drugs. By 1905, as chairman of the reference committee to which was referred the announcement of the establishment of the Council on Pharmacy and Chemistry, he made a succinct statement recognizing the great significance of the work. Through the years he supported and championed high standards in the manufacture, sale, and recognition of pharmaceutical products.

The battle against patent medicines and the campaign against the nondescript medical colleges brought Dr. Billings into active controversies which he fought vigorously and which, I think, he greatly enjoyed. He was never a man to dodge a fight for right.

In 1914 the American Medical Association was sued by the manufacturer of the Wine of Cardui for libel and Dr. Frank Billings was one of the witnesses. I heard him testify for some hours. Just before he left the witness stand, Mr. W.M. Hough, attorney for the Wine of Cardui company, said to him:

Q.—Just before you get off the stand, doctor, will you explain to the jury the difference between puberty and nubility? A.—And what?

Q.—The difference between puberty and nubility? A.—I don't get your last word.

Q.—Nubility. A.—Nobility?

Q.—N-u-b-i-l-i-t-y. A.—Nubility: you've got me.

As a witness he was calm, authoritative, and yet with a fine sense of humor impressed the jury with his warm personality.

In 1907 the American Medical Association created its first organization for health education—the Board of Public Instruction—of which Dr. Billings was a member.

During the first several years of its existence the Scientific Exhibit of the American Medical Association was part of the Section on Pathology. Dr Frank Wynn of Indianapolis was its motivating spirit. By 1903 it was so important that it was placed in the House of Delegates which appointed a committee on Scientific Exhibit each year. Finally the Board of Trustees, at the instigation of Dr. Billings, assumed control of the exhibit in 1921.

By 1921 the battle on compulsory sickness insurance was beginning to come to a focus. At that time Dr. Billings was subjected to a personal attack in the House of Delegates led by Edward H. Ochsner of Chicago. A circular quoting a statement alleged to have been made by Dr. Billings and published in the *American Labor Legislation Review* in 1917 was circulated in the House of Delegates. It charged that Dr. Billings was reported to have said that he was "unequivocally in favor of compulsory insurance and the protection of maternity." He had during that year recommended the establishment of health centers and the circular attacked this movement as "being the shortest route possible to state medicine." When this charge was made in the House of Delegates Dr. Billings said, "I

have declared in published articles that compulsory health insurance was not applicable to the United States and that I am opposed to it, and that state medicine as related to the treatment of disease I look on in the same way." He recognized that the attack made on him was in effect a charge of duplicity. He simply referred to his career in the American Medical Association including membership in the House of Delegates for eight years, the presidency of the association, and membership on the Board of Trustees. The House of Delegates unanimously expressed its confidence in Dr. Billings.

Dr. Billings came to Chicago from Wisconsin as did John M. Dodson, Nicholas Senn, John B. Murphy, and Henry B. Favill. He had attended the state normal school and taught in the district school at Plattsville and later became principal of the local high school. In 1878 he entered Chicago Medical School from which he graduated in 1881 and in that year made first place in the Cook County Hospital examination for internships. In 1882 he became associated with Christian Fenger and he served as demonstrator of anatomy in his alma mater. He taught physical diagnosis at Northwestern and from 1891-98 was professor and head of the department of medicine and dean of the medical school. In 1898 he became associated with Rush Medical College as professor of medicine and dean of the school. Then when Rush became affiliated with the University of Chicago he served for 25 years as dean and professor of medicine. This affiliation was an accomplishment of Dr. Frank Billings through his association with President William Rainey Harper. He was instrumental in developing the Presbyterian Hospital, the John McCormick Institute for Infectious Diseases, the Durand Hospital, the Otho S.A. Sprague Institute, the School of Medicine in the University of Chicago, the Billings Memorial Hospital and the Frank Billings Clinic and Library, and the Lasker and Douglas Smith Foundation for Research.

In 1927 the Section on Practice of Medicine established the Frank Billings Lecture. The first lecture was presented in Detroit in 1930 by Dr. Joseph L. Miller. In Chicago Dr. Billings was instrumental in organizing the Pathological Society, the Chicago Neurological Society, the Society of Internal Medicine, and the Institute of Medicine of Chicago. At the time of his death at age 78 in 1932 it was estimated that at least 100 of the medical teachers and clinicians of our country had been his personal assistants and students.

Dr. Billings was tall; he gave the impression of bigness; he was genial, sympathetic, and full of humor and human kindliness. He radiated power. In meetings of directors or of his colleagues on occasion he burned with emotion and by the innate force of his personality carried all before him. Probably the most significant fact of his career was his record of battles for right waged in medicine, in politics, and in every field into which he entered. It is hard to find an account of any battle that he ever lost, except those that every physician loses to the Angel of Death. While in practice he was a doctor's doctor; he was called again and again when every one else had given his utmost without success. One afternoon while I was walking toward the city with him, he said:

"I dread to get to my office!"

When I asked "Why?" he answered:

"There will be 14 or 20 people waiting and eighty per cent of them will be relatives of doctors."

The same power that carried the conflict in the counsel room gave renewed hope to the patient who had begun to despair.

One day he said to me:

"I have often tried to remember who was the first patient to give me a fee of any considerable amount. As nearly as I can remember she was a lady of leisure and morals that were none too good. She called me late one night while in a condition that combined shock and inebriation. After I treated her she told me to help myself to a few of a roll of bills big enough to choke a proverbial horse. The roll was pinned to the top of her stocking!"

The innumerable anecdotes of Dr. Billings could occupy hours and hours and many of his experiences on witness stands have become apocryphal. He told me dozens of his experiences in checking the mental institutions of Illinois.

After Dr. Billings grew old he did not falter in his efforts for the advancement of what was right and good. I saw him toward the end at a meeting of the Board of Governors of the Institute of Medicine. Where he sat was always

the head of the table. He had made up his mind to oppose some issue. Drs. Hektoen and Herriek had asked me to attend and give some speeial information on the subject. Billings sat like a smoldering voleano. As I eame to my conelusion he gradually rumbled to an explosion:

He said: "God damn it, Fishbein; you know better than that!" And he struek the great table with two powerful hands whieh made it almost leap from the floor. And that ended the discussion!

This was a great man—the greatest of all the physieians I have known in Chieago; so great, in faet, that the writing of his biography seems to have been an insuperable task for his biographers. May it be fortheoming soon!

When I came to Chieago in October 1906 the cable ears jerked their way southward on Cottage Grove Avenue, the motor car was still somewhat rare, and the praetiee of medieine was largely in the hands of general practitioners. A few names of surgeons, otolaryngologists, obstetricians, and pediatricians were known but specialization had not yet been formalized.

Came 1908 and I matrieulated in the medical school under John M. Dodson, dean, and made the acquaintanee of Harvey, Carlson, A. P. Mathews, Bensley, H.G. Wells, C. Judson Herriek, and the other distinguished men of that faculty. I still had not met an internist and I did not happen to need any other doctors. Then in September 1910 I went over to the West Side and, as related previously, met Ludvig Hekteon with whom I beeame associated. In addition to James B. Herriek and Frank Billings I saw frequently E.C. Rosenow, George Diek, E.R. LeCount, Karl K. Koessler, Ralph Webster, George Weaver, and many others. I doubt that a similar opportunity was had then or is had now by any other medieal student, unless it was George Coleman who began to do postmortems with LeCount at the same time as I did. No doubt Coleman knew the men of whom I speak as well or better than I.

Mueh of what I shall have to say about the internists of the last 50 years in the eity of Chicago will refleet my eontaets with them in my position with the *Journal of the American Medical Association.*

The American Board of Internal Medieine was established in 1936 by joint aetion of the Council of the Section on Praetiee of Medieine of the Amerieau Medical Association and the Board of Regents of the American College of Physieians. In the early 1900's everyone knew that Billings, Herriek, Sippy, Quine, Mix, Preble, Tieken, Slaymaker, Miller, Post, Capps, Edwards, Elliott, and a good many others were internists.

I well remember the furore associated with the establishment of the Amerieau College of Surgeons and the subsequent establishment of the American College of Physicians. When medieine in Chieago was undergoing purgation and growing pains in the early days of the 1900's it needed statesmen more than internists. Fortunately many of the internists had statesmanlike qualities which were to determine the plaee of the speeialty not only in Chicago but throughout the nation.

WILLIAM E. QUINE

Before 1900 the name of William E. Quine no doubt outranked any others among Chieago internists. Dr. Quine was the second internist appointed to the Cook County Hospital, a position whieh he took in 1869. Describing later the obstetrieal service in the hospital at that time he said:

"Baeteriology and hematology were undeveloped and asepsis was unknown. Interns engaging in postmortem work or who were in touch with erysipelas or gangrene were assumed to have no eonneetion with obstetrical eases, but there was no stern rule against it, and they thought no ill of maintaining friendly relations with laudable pus. Puerperal infeetions were frightfully frequent and deadly, and the obstetrical ward was elosed on two or three oeeasions for several weeks on aeeount of them. During these intervals the windows were kept wide open night and day. Atomizers were kept busy sputtering weak antiseptie vapors into the atmostphere. Walls and eeilings were freshly whitewashed and all woodwork was serubbed with antiseptie solutions, but the old deadly ignoranee of personal transmission of infeetion eontinued."

In 1881 the College of Physieians and Surgeons of Chieago had been organized by five ineorporators who put up $30,000. Dr. Quine was added to the faculty in 1883 when he was appointed professor of medieine. His dominant

personality, wisdom, eloquence and professional spirit were fundamental in the growth of this great medical school. In 1893 the capital stock was increased to $100,000 and at that time the faculty of the College of Physicians and Surgeons built the first medical laboratory building for medical students in Chicago. In 1893 Governor Altgeld undertook negotiations with Professor Quine which resulted in the affiliation of the college of Physicians and Surgeons with the University of Illinois, and in 1897 a lease was made to the university of the college property for four years.

William E. Quine was a broadminded man and was largely responsible for permitting women to take the examination for internships in the Cook County Hospital, which was done first in 1879. In fact, in 1881 Mary E. Bates, then not quite 21 years old, was notified that she had passed for the position of intern in Cook County Hospital.

Dr. Quine was a cultured gentleman and during the 22 years of his service as dean of the faculty at the University of Illinois he devoted himself with great zeal to building the college library. That library was begun in 1892 when the widow of Dr. A. Reeves Jackson, a gynecologist who had been a founder of the college, donated 30 books. Inside of two years enough were stolen so that only 15 remained. Dr. Bayard Holmes also did a great deal to build that library. In 1898 Dr. Quine contributed 2,000 periodicals and 200 separate volumes and endowed the library with $300 annually and paid the librarian out of his own pocket. The library was formally named by the faculty the Quine Library in 1898. The public library movement really began to develop in the period between 1880-90 At that time Christian Fenger, Quine, Billings, Bayard Holmes, Hektoen, George Weaver, Mortimer Frank and others were collecting books for their own libraries and most of these eventually came to swell the collections in the great medical libraries which now grace the city of Chicago.

In 1898 Frank Billings accompanied John Crerar on a trip to Atlantic City. Perhaps that helped toward the endowment and establishment of the famouns John Crerar Library.

George Weaver, who was one of the founders of the Chicago Society of Internal Medicine, was for many years a practitioner but joined with Dr. Ludvig Hektoen in the McCormick Institute for Infectious Diseases when that institute was established, largely through the influence of Frank Billings and Harold F. and Edith Rockefeller McCormick. The McCormicks had a son named John who died of scarlet fever and the John Rockefeller McCormick Institute for Infectious Diseases was established in his memory. Dr. Hektoen became the director and Dr. George Weaver his assistant. Dr. Weaver was largely responsible for the preparation of antitoxins and serums.

When I came to the institute other workers were Karl Koessler, distinguished as probably the first allergist in the Chicago area; E. C. Rosenow, Roswell Pettit, later to be joined by George F. and Gladys Henry Dick, Ruth Tunnecliff, occasionally Alice Hamilton, Harold Eggers, and a few others.

When H. Gideon Wells came to Chicago fresh from eastern schools, he came to see Dr. Hektoen and asked him about doing some research in the Institute. Dr. Hektoen welcomed him and told him he would be glad to provide space. Dr. Wells asked, "Where can I get some glassware?" to which Dr. Hektoen replied, "That is your first research!"

Dr. Koessler had come from the European universities and still had a good many of the characteristics of those trained in Germanic nations. I remember once that he was using the centrifuge and had stepped away leaving his materials in the centrifuge. We did not have too many of anything at that time. Dr. Eggers came in and wishing to use a centrifuge stopped it and carefully removed the material that Koessler had put in. When Koessler returned there was one of the merriest battles that I have ever witnessed — nearly better than the Monday night fights on television which are not nearly as good as the Wednesday night or Friday night fights. However, at the point where Koessler was advancing on Eggers to do bodily harm—and Eggers who was one-fourth his size had armed himself with a laboratory stool — Hektoen stepped in and in three or four words quieted the fracas.

These were the days when Rosenow had just begun to find streptococci and Billings was developing his thesis on focal infection. After a visit from Victor Vaughn, who had begun work

with quarts of tubercle bacilli, Rosenow managed to secure from the Du Vall Milk Separator Company a centrifuge which could separate four pints at a time. He filled it with streptococci and set it going at the highest speed. I remember a sudden uproar when the whole machine disintegrated and streptococci were scattered far and wide — a half bucket narrowly missing the head of George Dick who had also rushed in to see what was happening.

When the Durand Hospital was built and opened for patients the first six patients were nurses from Presbyterian Hospital which was then undergoing an epidemic of scarlet fever. They were almost immediately followed by Gladys Henry who was at that time teaching pediatrics at Rush Medical College and doing research at the Presbyterian Hospital. At the suggestion of Dr. Weaver I injected her with 60 cc. of antistreptococcus serum in one series of injections. Within about two hours her temperature was 106, at which time I, as resident, decided to call for help. I could not reach Dr. Weaver who was then in the suburbs but Dr. George Dick came running and remained with the patient, giving attention and treatment for some 36 hours. Shortly afterwards Drs. Dick and Henry were married and went to work together on their successful search for the cause, prevention, and treatment of scarlet fever.

Dr. George Weaver was also especially interested in medical history. He was a frequent contributor to the meetings of the Society of Medical History and to its bulletin. Later I succeeded Drs. Mortimer Frank and Stanton Friedberg as editor of this bulletin and was, in turn, succeeded by George Coleman. For many years George Coleman has served as secretary and guided the destinies of the Institute of Medicine of Chicago — the kind of devoted service to his professional colleagues that his mentor, Frank Billings, to whom he was the last assistant, was wont to give.

Ruth Tunnicliff was constantly receiving letters from all over the world addressed to Mr. Tunnicliff Ruth because that was the way her name was always listed in foreign literature.

One of the most exciting incidents in my career took place in 1923 when Sinclair Lewis came to Chicago shortly after writing "Main Street" and "Babbitt." He visited me at that time and I had the pleasure of introducing him to Paul DeKruif who had left the Rockefeller Institute and who was doing a series of articles for the Hearst magazines on patent medicines which had a high alcoholic content. DeKruif came to the offices of the American Medical Association and sampled some 25 different preparations which we had available, including Lyko, 37 Indian Herbs, Lydia Pinkham's Vegetable Compound, Tanlac, Swamproot, and a number of similar concoctions. Around 4:30 I drove Lewis and DeKruif out to my apartment where DeKruif proceeded to become terribly sick. At that time Sinclair Lewis was planning to write a novel about labor with Eugene Debs as the protagonist. Debs was just released from prison and was now in Victor Lindlahr's sanitarium in Elmhurst — a naturopathic sanitarium devoted to a diet of hay, grain, oats, walking barefoot in the dew, and similar naturopathic vagaries. The story of our trip to see Eugene Debs by motor car, accompanied by many vicissitudes, is another story but we finally arrived in Elmhurst about 2 a. m., Debs came down in a robe with a half pint of whiskey and we sat on the step talking until 4 in the morning. Then we went to visit Carl Sandburg who lived in Elmhurst and arrived in Chicago at 6:30 for breakfast at the Bismarck. During this ride I persuaded Lewis to write a medical rather than a labor novel.

About two years later I received a telephone call from the brother of Eugene Debs stating that Debs was again in the sanitarium and that he was desperately ill and had asked him to call me. Help was needed. I called George Coleman and Frederick Tice and we all went to see Debs. He had had a hemorrhage while returning from a visit to see Carl Sandburg and had been treated in the sanitarium for three days without receiving any fluid and receiving considerable doses of diathermy and injections of Cactine. His heart was fibrillating and he died the next day. I doubt that I shall ever forget that evening, and I know that Frederick Tice and George Coleman were well nigh aghast to see and hear what naturopaths do under difficult circumstances.

I have written elsewhere the story of my trip to Escanaba, Michigan, with Rollin Woodyatt to see a young woman who had been for some weeks allegedly running a fever of 119-120 and

whom I have described as "The Hot Girl of Escanaba." She was an interesting case but most interesting to me because I had a chance to see Woodyatt in action. He was a great bridge player, a recognized authority on diabetes, and one of the first of the biochemists who now bid fair to be kings of the medical profession. Woodyatt contributed greatly to early studies of water balance.

JAMES B. HERRICK

On July 22, 1893, James B. Herrick published his observations on experience with nearly 1,000 cases of typhoid seen in the Chicago area.

Dr. Herrick was born Aug. 11, 1861, in Oak Park, Illinois. He attended the Oak Park High School and the Rock River Seminary at Mount Morris, Illinois. He received his A.B. degree from the University of Michigan in 1882. For a time he taught in the Central High School at Peoria, Ill., where he acquired a love of good literature and a facility for expressing himself in the English language. Through an association with Moses Coit Tyler he developed a great interest in Chaucer. Dr. Herrick then took up the study of medicine, receiving the degree of Doctor of Medicine from Rush Medical College in 1888. His internship was served in the Cook County Hospital and in 1889, after completing his internship, he married Miss Zellah P. Davies of Oak Park.

Dr. Herrick contributed greatly to the periodical literature of medical science, he taught in his Alma Mater, and he was widely known for his contributions particularly to our knowledge of coronary thrombosis. Indeed, his articles on coronary thrombosis did more to force clinical recognition of the condition and to stimulate clinical and experimental study than all other writings on the subject. Probably most significant was the contribution on "Clinical Features of Sudden Obstruction of the Coronary Arteries" published in 1912. In his career as a physician he was instructor in medicine at Rush Medical College from 1890 to 1894, adjunct professor from 1894 to 1900, professor from 1900 to 1927, and then professor emeritus. He was attending physician at the Presbyterian Hospital in Chicago since 1895 and a member of the board of trustees of the Lewis Institute from 1903.

He served as president of the Association of American Physicians, the Institute of Medicine of Chicago, and of the American Association of the History of Medicine. In 1930 he received the Kober Medal of the Association of American Physicians for Research and Scientific Medicine. In 1931 he gave the sixth Harvey Society Lecture at the New York Academy of Medicine on the Coronary Artery in Health and Disease, and in 1933 he was elected honorary fellow of the New York Academy of Medicine. In 1932 he received the honorary degree of Doctor of Laws from the University of Michigan, and in January 1939, at the 194th convocation of the University of Chicago, the honorary Doctorate of Science was conferred upon him.

Throughout his career he was of vast assistance to young men and a builder of medical institutions. He was founder and first president of the Chicago Society of Internal Medicine. From 1928 to 1934 he was a member of the Judicial Council of the American Medical Association. The House of Delegates of the American Medical Association awarded him the Distinguished Service Medal in 1939.

In March 1902 Dr. James Herrick was appointed a member of a committee along with Alfred Stengel of Philadelphia and William H. Welch of Baltimore to encourage scientific research. The American Medical Association appropriated $500 annually for research and perhaps somewhat satirically the next year Dr. Stengel reported that "no steps had been taken to encourage scientific research by the utilization of the generous appropriation of the Association."

JOSEPH L. MILLER

In 1907 the Board of Trustees of the American Medical Association decided to establish a magazine of internal medicine. Letters came from many leaders at the suggestion of Dr. William H. Welch and a committee including Drs. Joseph L. Miller, George Dock, William Sidney Thayer, and David L. Edsall was established to report to the board on the publication of such a journal. Dr. Welch suggested that these men should constitute the editorial board in case the journal was agreed on. As a result the *Archives of Internal Medicine* was established and Dr. Joseph L. Miller became its editor. The *Archives of Internal Medicine* fell into a fracas in 1932. At that time the editorial board, which consisted

of Drs. William S. Thayer, J. D. Heard, W. T. Longcope, Richard C. Cabot, J. H. Means, and Walter W. Palmer, resigned as a body. The battle involved failure of the board to renominate the chief editor, Dr. Joseph L. Miller, who had been editor for 25 years. Some difficulties had arisen over the acceptance of material and over the editing of a manuscript but the greatest difficulty was that Dr. Miller had decided to object to advertising in the publication. The Board of Trustees voiced its opinion that it had to maintain its own responsibility over the conduct of its publications. Hence the entire board resigned and a new board, headed by N. C. Gilbert, was appointed.

Joseph Miller by his intrinsic honesty, clinical acumen, and high ideals added greatly to the lustre of Chicago medicine.

Among those associated with the faculty of Rush Medical College during its period of greatness and leadership were Sippy, Capps, Irons, Portis, Bloch, Slaymaker, Post, Tieken, and Walter Hamburger. All were outstanding as teachers, contributed to the literature of medicine, and advanced medicine in many ways. Dr. Capps contributed important studies on the localization of pain and on red cell volume. The Sippy regimen for peptic ulcer swept the world after its introduction in 1910. A meeting of the Chicago Medical Society was held shortly thereafter in the cafe on the sixth floor of Marshall Field's store for men. Among the participants in a symposium on peptic ulcer were B. W. Sippy, William H. Mayo, and John B. Deaver. Dr. Sippy spoke first, outlining his regimen for this disease. Dr. Mayo suggested that surgery be used after twelve medical treatments had failed. Then John Deaver poked satire and ridicule on the Sippy method and finally Sippy leaped to his feet and shouted: "You're a liar, Deaver, and you know it." And Deaver said: "Sit down Sippy." And Sippy sat down. Symposiums were exciting in those days.

Sippy, I believe, was a great teacher because he had a mind that classified and organized facts and he was full of enthusiasm. In his excitement he would climb on a chair speaking in his clinics to hundreds of students. He would jump from the chair to write outlines on his blackboard. I heard him at a meeting of the Rush alumni when he was toastmaster in 1917. He said he had expected the honor for some time but only recently apparently had he become sufficiently mature to get it. He complained bitterly that he was not supplied with a blackboard. With the same technique that he employed in lecturing on ulcer he classified toastmasters:

1. Personal appearance
2. Speech written by the toastmaster or by someone who knows how
3. Manner of delivery
4. Manner in which the audience receives the effort

Then he turned with his usual thoroughness detailing his methods of research and the review of the literature:

> I first consulted Webster and looked up master; then the different kinds of masters, such as paymasters, dog masters, masters of science, master plumbers. Then I looked up allied subjects such as mistresses. I found different kinds of mistresses such as school mistresses, and post mistresses. Then I looked up toasts and the different kinds of toasts — buttered toast, milk toast, French toast, and toasted corn flakes.

He spoke then of Rome, soft skies, and poetry and introduced Italo Fred Volini, president of the class, who had just made first place in the county exams. That year Rush made 41 out of 68 places.

Among the charter members of the Chicago Society of Internal Medicine were many fine internists who were noted for the manner in which they kept abreast of rapidly advancing knowledge. Their patients admired them and they earned the admiration and trust of the thousands of students whom they taught. Robert Preble was a sound clinician somewhat addicted to therapeutic nihilism; John Favill, son of a distinguished father, really preferred neurology; Charles Elliott was a distinguished educator and medical leader; Charles Mix had a tremendous practice and was esteemed as a consultant; Charles Williamson was placed during World War I as head of the Army Sanitary Corps. He wrote a book on the subject and became a brigadier general in times when it meant much more than now. Samuel Slaymaker was a calm, judicious person, whose very presence radiated confidence.

Those men practiced medicine in preantibiotic

days, yet they did marvels with what they had. Psychoanalysis and psychosomatic medicine were not yet scientifically formulated yet informally they utilized in their practices understanding often far before their times.

At a meeting of the Chicago Medical Society devoted to pneumonia back in 1920 physician after physician described their experiences. Dr. Billings dwelt on the care of the heart and good nursing service; some spoke of venesection; John Dill Robertson, then health commissioner, mentioned his success with echinacea, a herb frequently prescribed by the eclectics. Then arose one Dr. Johnson of South State Street who spoke gravely: "I have used all the various remedies which the different doctors have mentioned. It has been my experience that most of the patients generally died."

In the new order the great amphitheatres have gone and distinguished practitioners no longer sway hundreds of students with drama and eloquence. Many a diagnosis is made primarily in the laboratory and X-ray departments. The finesse of personal examination is taught at the bedside to small groups of students by individual example. The techniques of science have dulled the riotous color of a former day. The competition between private schools of medicine no longer prevails and mass techniques build adequate funds. These giants of an earlier day practiced great medicine and built great medical organizations and institutions against what seem now like insuperable odds. No doubt with the advantages of modern progress they would have achieved heights even greater.

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Recent viral studies

The recent report that many different viruses have been isolated from monkey renal tissues which had been used in the production of poliomyelitis vaccine represents another interesting example of the unmasking of viruses from cells. The many ideas implicit in new information of this sort cannot be developed here. Perhaps the most important point is that whole areas of acute and chronic human disease, unexplained except that they are assumed to be noninfectious in origin, must be reexamined in the light of the new concepts concerning the nature and consequences of viral infections. The simple fact that from two tissues, the human adenoid of man and the kidney of the monkey, 25 or more immunologically distinct viruses have been unmasked, supports the concept that the human cell itself must be regarded as having a considerable viral flora. Should this concept, which is not new to those working with bacterial and plant viruses, prove to be true, it cannot fail to have tremendous influence upon future investigations into the cause of human disease, regardless of its apparent lack of connection with microbial infection. For instance, a virologist can hardly conceive how human cells could remain uninfluenced by the viruses growing within them and, furthermore, how such experiences could fail to be an important factor in the malfunction and erosion of cells which the clinician calls degenerative, or chronic disease. *Robert J. Huebner, M. D. Implications of Recent Viral Studies. Pub. Health Rep. May* 1957.

Evaluation of Analgesic and Sedative Properties of Aminopyrine-Diallylbarbituric Acid Combination

PAUL F. NORA, M.D., AND JOSEPH M. LEYDON, D.D.S., CHICAGO

SINCE the basic concept of the complimentary effect of sedation upon analgesia was established,[1] the use of two such drugs being administered concomitantly has had widespread application. An example of this is in preoperative medications where a barbiturate and narcotic frequently are given together. The combination of aminopyrine and diallylbarbituric acid is an example of this type of synergism.

It has been shown that the analgesic potency of aminoprine was equal to acetysalicylic acid.[2] The first question was whether aminopyrine in combination with diallylbarbituric acid showed a marked difference in analgesic potency as compared with aminopyrine alone. To evaluate the analgesic effect in humans, some form of well-defined pain must be used as a guide. It is generally considered that pain due to traumatic bone injuries is undoubtedly one of the truest forms of pain. Following the above rationale, 129 acute fracture cases were treated with aminopyrine-diallylbarbituric acid combination. Each patient was given two tablets of the above combination upon admission to the fracture ward. They were then evaluated from a period of 30 minutes to 4 hours for analgesic effect. Any associated medication given was also noted. To evaluate the therapeutic effect of the drug, two main criteria were used:

(1) Subjective statement of patient

(2) Response to pressure over or near fracture site

In attempts at an associated control study, acetylsalicylic acid, phenacetin, caffeine combination was given. However, it was soon seen that with injuries of this severity, no appreciable effect was noted due to the control drug. This tends to substantiate the work of Haffner[3] who claimed that acetylsalicylic acid has no analgesic effect. Many authors [4,5,6] agree with this concept—namely, that acetylsalicylic acid shows no analgesic effect while aminopyrine is the only non-narcotic drug with any analgesic potency. However, Hesse[7] and Hildebrandt[8] found the reverse to be true. Sivadjian[9] was unable to discover any analgesic influence from either drug, but in this group of patients, the problem was not whether aminopyrine was superior to acetylsalicylic acid for analgesia, but rather was aminopyrine-diallylbarbituric acid more effective than aminopyrine alone.

A gradation system of 1-4 was used, cases with a marked response being classified as 4, while those with minimal effect were classed as grade 1. The results were graded as follows: Marked, class 4; Moderate, class 3; Mild, class 2; and Poor, class 1.

Results as follows:

Group No.	Cases
1	46
2	48
3	33
4	2
TOTAL	129

The majority of the patients fall into Classes 1 and 2. This is not surprising because narcotics frequently were necessary to help alleviate pain resulting from some of the severe fractures. It must be remembered that we are dealing with a severe form of pain and the therapy frequently falls into the realm of narcoties. It should be

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Aided by research grant from Ciba Pharmaceutical Company for the study of Cibalgine, (aminopyrine-diallylbarbituric acid combination).

reaffirmed that this source of pain stimulus was chosen because of:

(1) The true character of the pain

(2) The severity of the pain which allows gradation of the analgesic being evaluated

The second question was whether diallylbarbituric acid in combination with aminopyrine showed a marked difference in sedative potency compared to diallylbarbituric acid alone. Here again we had a problem similar to the analgesic evaluation. We attempted to find a suitable method for evaluating sedative qualities of aminopyrine-diallylbarbituric acid. It is well known that diallylbarbituric acid alone[10], like most barbiturates, has been proved to be a good sedative. But in the case of aminopyrine-diallylbarbituric acid, we attempted to find if this combination offered something more than the routine "sleeping tablet."

We selected 98 ward patients who had suffered recent bone injuries and who were being treated either in traction (skin and skeletal) or plaster immobilization, which provided an added factor of discomfort. Criteria for evaluation were difficult, but personal interview was of assistance because most of them had received some other form of sleeping tablet on previous evenings. The grading was similar to the above group. The results were as follows:

Group No.	Cases
1	8
2	25
3	50
4	15
TOTAL	98

Here the majority is in Group 3. It should be remembered that the test for analgesic potency of aminopyrine-diallylbarituric acid was more severe than for the sedative potency of the drug. In the former group, test subjects were acute fracture injuries in comparison with partially or completely immobilized patients in the latter.

The third group of patients tested consisted of 23 patients with oral surgical problems whose main presenting symptoms were toothache, or sore gums. The main feature evaluated was the analgesic potency of the drug. However, in this group the degree of pain stimulus was much less pronounced. The majority of patients fell in Groups 2 and 3.

CONCLUSIONS

From the above clinical material we reached the following conclusions:

Aminopyrine-diallylbarbituric acid, from the analgesic standpoint, is probably better than the routine analgesic. However, even in the oral surgical problems, where pain was not severe, aminopyrine-diallylbarbituric acid was far from perfect. In relation to the sedative capacity, the results were better. From this group of patients, aminopyrine-diallylbarbituric acid could be established to be a better sleeping pill than any of the routine barbiturates alone. In relation to side effects, none of the usual problems mentioned with aminopyrine-diallylbarbituric acid[11] or diallylbarbituric acid[12] were seen. However, this would be expected because the drug was used only once.

SUMMARY

(1) 250 patients were treated with aminopyrine-diallylbarbituric acid to evaluate analgesic and sedative potency.

(2) Sedative potency of diallylbarbituric acid is markedly enhanced by aminopyrine as compared to the increase of analgesic capacity of aminopyrine due to diallylbarbituric acid.

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Surgical Treatment of Pulmonary Cysts and Spontaneous Pneumothorax

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Pulmonary cysts occur at all ages from early infancy to late adult years. Those seen in infancy and childhood can be classified into four major groups—namely, obstructive lobar emphysema, true brochogenic cysts, cystic bronchiectasis, and tension pneumatoceles.

Pulmonary cysts encountered in adults are chiefly emphysematous blebs and bullae. Occasionally, true bronchogenic cysts are not discovered until adult life.

Pulmonary cysts require surgical therapy if symptoms or complications arise. Frequently a cyst expands and compresses the surrounding lung, producing dyspnea. The cyst may rupture into the pleural space, producing spontaneous pneumothorax. Following a respiratory infection, pulmonary cysts may become secondarily infected, causing lung abscess. Rarely, severe hemoptysis may be due to rupture of a blood vessel through the cyst wall.

PULMONARY CYSTS OF INFANCY

Congential obstructive emphysema may cause alarming symptoms of dyspnea, cyanosis, and difficulty with feeding. This may occur within the first few weeks of life. Usually one lobe or segment is involved. The air becomes trapped within this lobe by some type of check-valve mechanism. Some authors have attributed this to hypoplasia of the bronchial cartilage or to excess folds of bronchial mucosa. The most likely explanation is a congenital defect in the formation of the pulmonary alveoli. The lobe may become greatly distended and compress the mediastinum, great vessels, and contralateral lung. This produces a surgical emergency, requiring immediate thoracotomy with resection of the dilated lobe.

True bronchogenic cysts are epithelial lined cysts caused by blockage of the lumen of the bronchial buds. The wall of the cyst is lined with respiratory epithelium. The bronchial communication to the cyst usually is small. Often the cyst contains fluid which becomes secondarily infected. This is sometimes confused with empyema, resulting in open drainage. The only satisfactory treatment is lobectomy with excision of the entire cyst.

Cystic bronchiectasis is a congenital dilatation of the terminal bronchi, resulting in large dilated saccules in the periphery of the lung. These cystic spaces contain stagnant, purulent secretions, giving rise to cough, expectoration of much foul sputum, and occasionally hemoptysis. Pulmonary resection is the treatment of choice if the disease is localized to one or two lobes.

Tension pneumatoceles are seen frequently with pulmonary infection and suppuration, in infants with staphylococcal pneumonia. The cysts appear as single or multiple thin-walled cavities, occurring near the periphery of the lung. They are caused by a ball-valve action of thick, sticky exudate within the bronchial lumen, resulting in small areas of localized obstructive emphysema. It is important to recognize this condition, since this type of cyst will regress with antibiotic therapy. Surgical drainage or excision is not necessary.

PULMONARY CYSTS OF ADULT LIFE

Pulmonary cysts in adults are chiefly emphysematous blebs and bullae. They produce dyspnea by compression of the surrounding good lung. Occasionally hemoptysis may occur from

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rupture of a blood vessel on the cyst wall. This type of cyst rarely becomes infected. Quite often a thin-walled bleb on the pleural surface may rupture, producing spontaneous pneumothorax. The primary indication for surgical excision is dyspnea. Usually the cysts can be excised without sacrificing any normal lung tissue. Occasionally lobectomy may be necessary.

SPONTANEOUS PNEUMOTHORAX

Rupture of a pleural bleb is the cause of the vast majority of cases of spontaneous pneumothorax. Air escapes from the ruptured bleb into the pleural cavity and becomes trapped by the ball-valve action of the ruptured bleb. If a great deal of air leaks out, tension pneumothorax may occur, resulting in compression of the heart and great vessels, and may end fatally. For that reason, it is mandatory to make a correct diagnosis and institute proper therapy.

The usual symptoms are pain in the chest, dyspnea, and cyanosis. Quite often this condition is confused initially with coronary occlusion. Physical findings may be misleading. The diagnosis is readily established by chest X-ray.

There are three methods of treatment: Bed rest, intercostal closed drainage, and open thoracotomy. Conservative therapy of rest is indicated if there is only 15 to 25 per cent collapse of the lung. The lung will re-expand in the majority of these patients in two or three weeks.

Closed intercostal drainage is indicated in all patients with any degree of tension pneumothorax or with more than 25 per cent collapse of the lung. Using local infiltration of procaine for anesthesia, a small stab wound is made over the second anterior intercostal space. A small trocar is inserted into the pleural cavity. A soft, No. 16 French catheter is inserted through the trocar into the pleural space. This is connected to a water-seal bottle. In one or two days the lung is completely expanded and the catheter is removed. The patient is able to return to work in one or two weeks.

Open thoracotomy is indicated in patients having repeated attacks of spontaneous pneumothorax or in cases in which the lung fails to re-expand with closed drainage. The cysts are excised. The visceral and parietal pleura are rubbed with dry gauze and sprinkled lightly with sterile talc. This produces a pleural symphysis and prevents future recurrence. In the past four years, 35 cases of spontaneous pneumothorax have been seen by the author. Eleven were treated conservatively with rest, 20 by closed intercostal drainage, and four required thoracotomy. There were no complications.

SUMMARY

1. Pulmonary cysts require surgical therapy if complications arise such as dyspnea, hemorrhage, rupture, or infection.

2. Excision of the cysts or lobectomy is the treatment of choice.

3. Spontaneous pneumothorax results from rupture of an emphysematous bleb.

4. Closed intercostal drainage is the preferred treatment if more than 25 per cent of the lung is collapsed.

Unusual Collagen Diseases

Bernhard Chomet, M.D., Chief of Pathology, West Side Veterans Administration Hospital, Chicago.

Doctor Samter: Doctor Bernhard Chomet, Chief of Pathology at the West Side VA Hospital, Chicago, will present four case histories which illustrate the expanding scope of the topic, "Unusual Collagen Diseases."

Doctor Chomet: Thank you Doctor Samter. The number of "collagen diseases" is mounting. They include not only periarteritis nodosa, hypersensitivity angiitus, lupus erythematosus, dermatomyositis, and Wegener's granulomatosis, but also such divergent diseases as ulcerative colitis, idiopathic cardiac hypertrophy, pulmonary hemosiderosis, malignant nephrosclerosis as well as, at least in certain aspects, glomerulonephritis.

Efforts are being made to use histopathological criteria in defining and classifying collagenous diseases. Zeek tried to separate periarteritis nodosa from hypersensitivity angiitis, Goddard the anaphylactic granuloma from the Aschoff body, Fienberg the necrotizing granulomatosis (Wegener's granulomatosis) from rheumatic disorders, and Spear and Walker the lethal facial midline granuloma from Wegener's granulomatosis. One is reminded of the efforts of histologists in differentiating infectious granulomata solely on histopathologic grounds. Despite the well defined picture of a tuberculous granuloma, histopathology can never serve as final proof—identification of the tubercle bacillus is necessary to establish the diagnosis. Granulomata caused by different micro-organisms can be indistinguishable from each other. How much more difficult is the task of histopathologic differentiation of individual diseases in a disease group (the "collagen" diseases) which appears to be caused by an unnatural host reaction. Could it not be that in an attempt to split and subdivide we cover up rather than uncover the factor which unifies a variety of pathologic reactions and clinical states?

Spear and Walker emphasize the histopathologic changes which differentiate the facial lethal midline granuloma from Wegener's granuloma. Is it not equally important to note the resemblance of the same lethal midline granuloma to the granulomatous reaction of Hodgkin's disease? The thrombotic focal glomerulonephritis which occurs in Wegener's granulomatosis as well as in periarteritis nodosa and the embolic glomerulonephrius of subacute bacterial endocarditis are other instances of suggestive similarities.

The first case is a 41 year old white male, who has a history consistent with ulcerative colitis of one year's duration. He also complained of numbness of his feet of one month's duration. Muscle biopsy showed periarteritis nodosa. Shortly after hospitalization, he went into shock and died.

Gross photographs of large intestines show typical picture of ulcerative colitis. Microphotographs of kidneys and pancreas show healed and subacute periarteritis nodosa. Final diagnosis: 1. Periarteritis nodosa, 2. Ulcerative colitis.

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Comment: Levine, Kirsner, and Klots describe the absence of ground substance of the basement membrane in ulcerative colitis. In many areas, the mucosa had separated from the underlying connective tissue. In the intervening spaces, the authors found a homogenous PAS positive material. Biopsy sections from ulcerative colitis patients who responded well to ACTH therapy showed areas where the ground substance had returned locally. The authors suggest that the changes in the basement membrane and ground substance are associated with hypersensitivity.

Warren and Summers found evidence of vasculitis in 11% of their cases of ulcerative colitis. The medium sized submucous arteries were uniformly affected, although the overlying mucosa appeared to be unchanged in the early stages. The appearance of the vessels was often identical with periarteritis nodosa or thromboangiitis obliterans.

The second case is that of a 27 year old Negro male who complained of nausea, vomiting, headaches and nosebleeds in January, 1933. He had hepatosplenomegaly. Biopsies of epithrochlear lymph nodes showed non-caseating tubercle-like granulomata which were interpreted as hyperplastie tuberculosis or Boeck's sarcoidosis. Biopsies of skeletal muscle were compatible with periarteritis nodosa. Later, splenectomy was performed because of a leukopenia. Sections of the liver and spleen showed Boeck's sarcoidosis. In March, 1956, the patient had respiratory difficulties and at thoracotomy a lung biopsy was done whieh showed non-cascating granulomata.

Microphotographs from skeletal muscle show periarteritis nodosa and non-caseating tubercle-like granulomata. Mierophotographs from lung biopsy show numerous small non-caseating tubercle-like granulomata.

Diagnosis: 1. Boeck's sarcoidosis. 1. Periarteritis nodosa.

The coexistenee of periarteritis nodosa and Boeck's sacroidosis has been reported by several authors. Jackson and Kass feel that hypersensitivity is the pathogenetie meehanism in sareoidosis.

Case 3 deseribes a 26 year old white male who complains of anorexia, weight loss, fever, and cough of short duration. An X-ray revealed a large fusiform mass in the right hilar region. Because of the gradual enlargement of the x-ray shadow, an exploratory thoracotomy was performed, and a large adherent mass was found. Biopsy showed inflammation with extensive necrosis. Later, the patient developed large painful ulcerations of the tongue. His course was marked by rapid deterioration with joint pains and hemoptysis.

Gross photographs of lung show a large necrotizing mass occupying almost the entire right upper lobe of the lung.

Microphotographs of the lung and spleen show neerotizing granulomatous inflammation, with vasculitis within the inflammatory areas of the spleen. Sections from liver show numerous areas of focal granulomatous lesions. Microphotographs of kidney reveal focal necrotizing glomerulonephritis.

Diagnosis: Wegener's granulomatosis.

Wegener's granulomatosis was defined first by Klinger and then by Wegener. According to Wegener, it is characterizcd by necrotizing granulomatous inflammation of the nose, larynx, and pharynx. There are kidney changes resembling a thrombotic focal glomerulonephritis, and generalized arteritis resembling periarteritis nodosa.

Goodman and Churg who collected 22 eases from the literature and added 7 eases of their own found basically the same changes.

The fourth case is that of a 26 year old white male. He complained of weakness, chills, fever, hemoptysis, and a 10 pound weight loss of one month's duration. He was severely anemie on admission and treated with blood transfusions. On the seeond hospital day, granular casts and blood casts were seen in the urine. He rapidly developed congestive heart failure and expired despite digitalization and steroid therapy.

Microphotographs of lung show the pieture of subacute and ehronic pneumonitis with alveolar hemorrhage and diffuse hemosiderosis. Microphotographs of kidneys reveal diffuse subacuete proliferative glomerulonephritis. Sections from heart show the picture of healed Aschoff's bodies with typieal onion-skin appearance.

Diagnosis: 1. Pulmonary hemosiderosis, 2.

Subacute glomerulonephritis.

Review of the literature showed 45 cases of idiopathic pulmonary hemosiderosis below the age of 16; and 20 cases, including our own, above this age. According to Schaar and Rigler, pulmonary hemosiderosis is detected by X-ray in only two forms of the disease, the idiopathic form and that secondary to mitral stenosis. Females predominate in the cases reported below 16 years of age, while males make up the majority of the adult cases.

The natural history of idiopathic pulmonary hemosiderosis consists of recurrent episodes of dyspnea, hemoptysis, fever, and anemia. The disease is generally fatal although benefits from splenectomy and cortisone have been reported.

According to Schaar and Rigler, the autopsy findings in idiopathic pulmonary hemosiderosis are limited to the lungs. The lungs show brown induration; the alveoli are crowded with macrophages containing hemosiderin and fresh blood. The alveolar walls are thickened and show fragmentation of elastic tissue. Other authors have reported findings in other organs including myocarditis or subacute or focal glomerulonephritis.

The etiology of idiopathic pulmonary hemosiderosis has been the cause of considerable speculation. Fragmentation of elastic tissue, rupture of aneurysms in the region of anastomoses between bronchial and pulmonary arteries, and defects of vasomotor control of pulmonary capillaries, are some of the factors implicated.

Steiner felt that the frequent presence of positive Coomb's tests, high cold agglutinin titers, thrombocytopenia, eosinophilia, an asthma-like clinical course, and apparent response to splenectomy and steroids suggest a sensitization mechanism. Similarly, Parkin and associates compared the lung lesions in 7 cases of necrotizing interstitial pneumonitis which showed thickening of the similar changes noted by Cannon and Rich in hypersensitized animals. The necrotizing interstitial pneumonitis and glomerulonephritis with connective tissue of the alveolar walls, intra-alveolar hemorrhage, and organization of blood in alveolar spaces. Four of seven cases also showed arteritis. Hemosiderosis played no significant part in this series, but the same authors reported postmortem findings in a 57 year old uremic woman with extensive pulmonary infiltration: her alveoli were filled with macrophages containing hemosiderin. The authors felt that the recurrent hemoptysis was the result of necrotizing pneumonitis which had healed: hemosiderosis presented the only remnant of the acute pulmonary process.

Our case, then—subacute and chronic pneumonitis, pulmonary hemorrhage, hemosiderosis and glomerulonephritis — appears to be a connecting link in a disease which has an acute stage: necrotizing pneumonitis, and a chronic stage: pulmonary hemosiderosis.

In conclusion, it may be well to quote Wagner from his chapter entitled "Hypersensitivity" in the book on Analytical Pathology edited by R. Mellors:

"While allergic inflammation causes profound changes in collagen fibers and the intermediate substances, not all examples of human disease reflect such pathogenesis. The work of Altschuler and Angevine and Gitlin, which suggest a chemical unity of fibrinoid, cannot be substantiated. Fibrinoid studied in systemic lupus, rheumatic fever, scleroderma and polyarteritis has revealed significant differences. The proponents of hypersensitivity mechanism in the evolution of the morbid states have yet to conclusively establish the nature of the antigen or antigens involved."

To modify this statement somewhat, not only do they face the task of defining the nature of the antigen or antigens, but also they must disentangle the erratic reactions of the human organism to these antigens.

Doctor Samter: Doctor Chomet has made a case for a common denominator in the collagen diseases. Would you comment on his presentation, Doctor Pirani?

Doctor Pirani: I am grateful for Doctor Chomet's interesting presentation of four rare and intriguing cases. One wonders whether all these cases should be included under the catch-all term of "collagen diseases." In any case, the term "collagen diseases" is really a misnomer. The only thing that they have in common is that the etiology is unknown for all. The fact that there is a disturbed immune mechanism involved in some of them, does not mean a common etiology. For example, syphilis and tuberculosis both predominantly affect the interstitial connective tissues and both have pathologic features of vasculitis, granulomata, and involvement of immune mechanisms. Hypersensitivity

plays an important role in the character of their lesions. Still, one is due to a spirochete, and the other to the tubercle bacillus and certainly we would not think of calling these two conditions "collagen diseases."

It is my contention that we need strict criteria to label a disease as a disease of connective tissue. First, the disease should be systemic in nature. Secondly, the changes which occur in the connective tissues should be a prominent part of the picture. There should be a deposition of polysaccharide. Another characteristic is the condensation of collagen fibers, as is seen in scleroderma. Fibrinoid necrosis although often part of the pathologic picture cannot be considered characteristic, as it is seen in unrelated diseases like gastric ulcer and malignant hypertension.

Doctor Chomet: I agree with Doctor Pirani. We called our own case Wegener's granuloma only after exclusion of known etiologic agents, such as fungi. It is true that the lumping of diseases on the basis of histopathologic criteria does not mean there may not be immunologic and chemical differences.

Doctor Mark H. Lepper, Professor of Preventive Medicine: What is the incidence of pure periarteritis nodosa unassociated with evidence for other diseases?

Doctor Chomet: We have seen 3 such cases in about 600 consecutive autopsies from 1953 through 1956.

Doctor Samter: Is there any history suggestive of drug reaction e.g., to iodides in any of your cases?

Doctor Chomet: Not to my knowledge.

Doctor Max M. Montgomery, Associate Professor of Medicine: I am a "splitter" rather than a "lumper." I think that we are more likely to make progress in understanding these conditions in studying differences between them.

Doctor Lepper: There is a place for both splitters and lumpers in the study of these conditions many of which are diseases of atypical immune response. Why is there such a wealth of reactions in syphilis? Why does one person develop a gumma while another develops tabes dorsalis? Our goal must be to identify these tissue antigens that determine the site and clinical character of the disease. We can then refer to a back-log of well documented material such as that presented by Doctor Chomet today. We should not forget, however, that we may be dealing with the chance co-existence of two unrelated diseases.

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Rheumatoid arthritis occurs at all ages

Practically all joint diseases may occur in old age and perhaps the biggest danger in old age is to ascribe too many symptoms to degenerative changes that are shown by X-ray, thereby missing the other joint diseases, particularly rheumatoid arthritis. The other point I would like to stress is that rheumatoid arthritis at all ages is a reversible disease in a large percentage of cases and this may be even truer in older age groups. *Claire F. Ryder, M. D. et al. Symposium on Disease and Aging. J. Am. M. Women's A. June* 1957.

Inefficacy of Flexin Therapy for Spasticity Due to Spinal Cord Injuries

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One of the biggest problems that confronts the physician in spinal cord injuries is the treatment of spasticity. Almost daily a new drug is described for this condition and each must be evaluated separately. As of this date there is no effective drug with controls neurologic spasticity.

Arieff, Newman and Wasserman[1] reviewed the treatment of spasticity, including literature and recent methods at VA Hines Hospital. Methods for measuring spasticity and rigidity objectively in muscles also were reviewed. Although many treatments seemed to offer some amelioration, nothing was of lasting value. The difficulties in evaluating spasticity were elucidated.

Numerous glowing reports followed the introduction of Flexin® or zoxazolamine. W. Amoles[2] found it to be a mild muscular relaxant, better when used with Thorazine® but the results were not consistent. He noted also that when it did relax the muscles it decreased the muscle strength which is of importance to ambulatory patients. Side effects consisted of headache and vomiting, in doses of 3 to 6 grams per day. Abrahamsen and Baird[3] used Flexin in children with cerebral palsy; and said it decreased muscle spastieity tested against passive flexion. In 15 of 28 children results were encouraging, but there were side effects. They had three deaths which they said were not related to the drug.

Rodriguez-Gomez, Valdez-Rodriguez and Drew[4] said Flexin worked especially well in spinal cord spasticity, such as in multiple sclerosis, with undoubted reduction in spasticity in 14 of 18 patients. They felt the mass reflex in paraplegia was reduced. In paralysis agitans and hemiplegia the product was less helpful. They used a dose of 500 mg. three to five times a day. Sometimes improvements were noted two to four days after starting the drug and four patients showed objective improvement in two to four weeks. This latter observation I would say is of questioned validity since the drug is supposedly rapidly effective. This improvement probably was due to the remissions and exacerbations or the fluctuations in the spasticity commonly seen.

The most effective results have been reported in spastic children with cerebral palsy with doses of 250 mg. up to four times a day. In other spastic cases like multiple sclerosis, traumatic cord injuries and vascular accidents, results have been variable but it has been stated that its clinical use leads to enough reduction of spasticity to indicate that it is worthy or trial. Of 170 patients with neurologic disorders there was spasticity due to trauma and tumors. In 40, only 8 cases were considered to have good results, 7 fair, and 24 with no improvement. There were no side effects in 236 of 385 patients who have been assessed. The remainder had side effects involving gastrointestinal, central nervous system, and miscellaneous.

Subjective improvement is considered valueless because patients with spasticity are always looking for help and feel that whatever drug is used does them some good at first.

At the recent Fifth Annual Paraplegia Conference held at Hines VA Hospital, Weiss, D'Oronzio, Ebel and Lindenauer[6] presented their results with Flexin in spasticity. In three paraplegic and three quadriplegic cases using a dose up to 750 mg. four times a day, they found the drug ineffective. Side effects included light-headedness and weakness. Bors and Bradley[7] in discussing their paper, said their results were similar in that Flexin was in effective in spasticity.

From the Neurological Department, VA Hospital, Hines, Illinois and the Department of Neurology and Psychiatry, Northwestern University Medical School

METHOD AND RESULT

A total of 27 patients with spinal cord lesions having spasticity were given Flexin therapeutically. Three had multiple sclerosis; 12 were quadriplegic, and 12 were paraplegic due to gunshot wound or fracture dislocations.

Preliminary laboratory work consisted of routine urine and blood studies (red and white blood counts, differential, hemoglobin, blood chemistry consisting of NPN, total protein, albumin and globulin, calcium, phosphorus and phosphatase).

The trial therapy consisted of putting the patients on two tablets four times a day for the first day, i. e., 500 mg. four times a day; the following day this dose was raised to three tablets four times a day and the third day to four tablets, or 1 gram, four times daily. In other words, this was a rapid trial. Some patients remained on treatment for five or six days.

Some patients felt their spasms were better on one day but the next day they would say they were worse. In general, no patient improved on this therapy. Their spasms showed no improvement whatsoever, objectively or subjectively.

Routine laboratory tests were completely normal. In a few patients there were red cells and some white cells in the urine. I believe this is due to the bladder infection these patients have and not to Flexin. There were no changes in the blood chemistries taken above, before or after.

There were numerous side effects of the drug consisting of subjective complaints:

Dizziness	19
Blurring vision— difficulty in focusing	4
Nausea	4
Sleepiness	4
Feeling drunk	2
Vomiting	1
Headache	1
Developed rash which disappeared	1
Numbness in the leg	1
Weakness	1
Edema of the eyelid	1

SUMMARY AND CONCLUSION

Flexin, or zoxazolamine, although experimentally an effective drug in spasticity, we have found to be clinically of no value in neurologic spasticity due to spinal cord disease or injury. The maximum dose used was 4 gm. per day. There were many side effects. It is possible when the dose is larger than has been used here spasticity may be reduced by producing marked weakness, as has been noted previously in drugs like the myanesin group. This result is not clinically of value.

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The Use of a Tranquilizer in the Management of Behavior Problems in a Private Pediatric Practice

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Behavior problems in children constitute a large portion of the practice of many physicians. This is especially true in the case of pediatricians and, to a large extent, the general practitioner. In most of these cases, symptoms are fairly obvious, although they may be manifested in a wide variety of ways. The child may stutter, exhibit a pronounced tic or facial grimacing, chew his finger nails, cry easily, squirm in his chair, or become belligerent at the slightest provocation. The mother may point out, and the physican may easily see the irritability, nervous coughing, and other manifestations of poor child adjustment. There may be a history of enuresis or unexplained asthma-like attacks.

Other signs of abnormal behavior may not be so evident or may not be present when a child is brought before the family physician. The mother, who usually brings the child into the office, may describe persistent coughing, temper tantrums, or bizarre and unexplained abdominal pains which can be attributed to no evident pathology. Frequently school teachers, who spend almost as much time as parents with the children in today's modern society, can add even more detailed information about abnormal behavior. They are able to relate information concerning the restlessness, irritability, antisocial behavior, and occasionally persistent idiopathic vomiting or incontinence which plague almost every instructor in our progressive and competitive school systems.

Are such symptoms and manifestations of emotional problems normal in American children today? Such a question may seem unnecessary but recently a number of articles have appeared in the popular literature and press implying that a little tension and anxiety is a good thing—that all of us need a little to be normal. Usually such statements are made during the course of arguments designed to prove that a new class of compounds, the ataractics, are unnecessary, unsafe, misused, or overly utilized. These compounds, relatively new to medicine, have attracted widespread fanfare and it is becoming almost fashionable to join the chorus of those condemning the use of tranquilizing drugs in tension, anxiety, and some of the other manifestations of disturbed emotions.

Actually, what is the case? Certainly, all of us agree that a youngster with a presenting complaint of facial grimacing or a nervous tic differs from one who is first seen with acute appendicitis. In the one, a precise diagnosis usually can be made, utilizing the laboratory, the history, and the skills of the examiner. The results are striking and the therapy undeniably effective. The physician, patient, and parent alike can see the dramatic result in a short time.

However, we are unable to define behavior quite as precisely, and diagnosis and treatment are made much more difficult. In the case of a disturbed child, it is obvious that reassurance and sympathy alone are insufficient to correct the pattern of abnormal behavior which has developed. We have long had reassurance and sympathy at our command and we have long been aware that the results are a long way from ideal. The manifestations and afflictions which can be attributed to emotional disturbances can be just as crippling, just as painful, and just as severe to our young patients and their future development as appendicitis, pneumonia, and other medical conditions.

When we see a behavior problem in our office, it is important to attempt to determine the etiology. This is not always possible and it may be obscured in many ways. A careful history may reveal many things concerning the onset and development of the disturbance which is presented to us. We may find that family tensions,

sibling rivalries, fear of a teacher, and many other stress situations place some children under severe emotional strain. Perhaps all children and adults should undergo some tension and anxiety to develop properly, but when stress is such that it interferes with normal development, the process of learning, and proper emotional development, then this becomes a pathological process. Medical intervention and some form of therapy appear indicated.

If some single predisposing cause for the emotional disturbance can be found, the physician should seek to relieve it. Frequently, because of the complexity of the problem, this requires considerable time. In the interval, while this patient is still under strain and still manifesting his symptoms, he should be helped directly and in a great many cases the tranquilizing drugs now available are indicated. One of the problems that we have faced with these compounds is that the patient, and often physicians themselves, seem to think that these agents should relieve all tension magically and, in effect, cure the mental ills of all mankind. Why should they? As with any potent therapeutic agent, some patients respond better than others. Others fail to respond to one of the ataractics, but respond surprisingly well to another. Some show no improvement on low dosages, but marked change at higher levels. The increasing body of clinical information now being called to the attention of the medical profession indicates a growing list of conditions which do respond to the proper ataractic used at the proper time in the proper dosage.

All of these facts should be of no surprise in medical practice. The art of therapy should be basic in our profession. When using the tranquilizing drugs or any other therapeutic agent in the management of behavior problems, we are faced with the difficult task of evaluation of the therapeutic response. It must be remembered that the symptoms may be manifested only at certain times and the physician responsible for treatment may or may not be present when symptoms are most pronounced. Often when the youngster is seen in the office, he appears relatively normal and shows no evidence of tics, grimacing. stuttering, coughing, and the wide variety of other conditions previously mentioned.

We should not forget, however, that we have allies who can and are willing to help us. Parents can be intelligent assistants. As a matter of fact, we should remember that it was because of the abnormal behavior in one of their youngsters that the parent originally brought the child to see us in our office. We might say that the parent made the diagnosis before we did. In the same way they can help us to record progress notes that would indicate the value of any therapeutic agent or regimen employed. Additional information may be obtained from the teacher who, if properly approached and oriented as to what we are trying to accomplish, often can add important information to that available from the parent.

Such a study was carried out on 58 youngsters in whom various symptoms of abnormal behavior were treated in a private pediatric practice. All of these patients were given hydroxyzine syrup* and the assistance of the parents and, in some cases, school teachers enlisted in the evaluation of the results. After fully discussing the importance of their help, a questionnaire was furnished to the parents. They were asked to record all of their observations and to report whether, in their opinion, the medication was effective or not effective in the control of the youngster's behavior problem. Some typical case reports, drawn largely from the parents' notes, are given below. They include the objective and subjective observations of the attending physician.

CASE NO. 1: M.F. This 10-year-old child complained of frequent abdominal pains occurring at any time of the day, but especially while in school. Physical examinations of this child were entirely negative and hydroxyzine syrup was started with a dosage of four teaspoonfuls daily. In the questionnaire the mother reported that the child had noticeably fewer episodes of abdominal pain after two weeks on therapy and also reported that the child was less irritable and nervous. There was definite improvement.

CASE NO. 2: J.A. This 10-year-old child was the youngster of three siblings. He was first seen because of severe and frequent temper tantrums and was considered a behavior problem by his parents. He got along poorly with his parents and school playmates. Psychiatric evaluation had been recommended. Prior to this, however, he was started on two teaspoonfuls of hydroxyzine syrup three times a day and the questionnaire filled out by the parents indicated that although his symptoms were not completely relieved, the

*Hydroxyzine syrup (Atarax) used in this study was supplied by J. B. Roerig and Company, Division Chas. Pfizer & Co. Inc., Chicago, Illinois.

drug was a valuable aid in controlling his temper tantrums. He was considerably improved and at the present time there is no need for further psychiatric evaluation.

CASE NO. 3: A.A. This 5-year-old child was extremely irritable and had a nervous cough without any apparent physical cause which was annoying to the parents. Physical examinations were negative and the child, when seen by physician, was extremely irritable and excitable. Three teaspoonfuls of hydroxyzine syrup were given daily and the parents' observations revealed that the coughing was almost completely relieved and the child was much less irritable. After two weeks of medication, the drug was stopped and symptoms reappeared immediately. When medication was reinstituted, symptoms were again eliminated.

CASE NO. 4: W.B. This 6-year-old youngster was reported by his parents to be an extreme disciplinary problem. He was totally unable to play with other youngsters in the neighborhood. When the child was seen, the mother and the youngster both were extremely agitated and it was decided to place the child on hydroxyzine syrup, two teaspoons t.i.d. There was some question as to whether or not this child was suffering from some form of convulsive disorder and electroencephalograms were run. These were normal. After one week's medication, the mother reported that the drug was extremely effective and the youngster was not as irritable and unmanageable at home. The electroencephalogram showed no change. Medication was discontinued and symptoms reappeared almost immediately. At the mother's suggestion the medication was again started.

CASE NO. 5: B.B. This 8-year-old youngster had repeated attacks of what appeared to be asthma during the summer hay fever season. Physical examination of the child revealed bilateral expiratory wheezes compatible with asthma. It was decided to use hydroxyzine syrup in a clinical trial at the dosage of three teaspoons a day and symptoms were entirely eliminated with no further attacks of asthma during the period of medication. The mother felt the medication was extremely effective in avoiding subsequent asthmatic attacks.

CASE NO. 6: S.M. This 9-year-old child was a markedly excitable, irritable youngster and had been for most of her life. Several physicians, including neurologists and psychologists, had evaluated the child and stated that there was a slight degree of mental retardation. The child also revealed nervous tics including coughing, stuttering, and grimacing. There were frequent temper tantrums and, not infrequently, episodes of nervous vomiting without physical cause. The mother complained that this child was unable to sleep and was up and about virtually the entire night. Physical examination revealed a well developed, well nourished, white female who was extremely uncooperative during the physical examination. It was the impression during the physical examination that this was a behavior problem with questionable mental retardation and the child was placed on hydroxyzine syrup with a dosage of six teaspoonfuls daily. The drug was readily accepted. After two weeks of medication the mother reported on her questionnaire and at a visit to the physician: "There was a definite sharpening of the child's senses, there appeared to be a greater ease in her learning ability, and she was more relaxed during the day. She slept practically all night." Prior to this medication this child had received several other ataraxic drugs with no benefit and, apparently, no effect. On the questionnaire the mother rated this preparation as being effective for her child and no side effects were reported.

CASE NO. 7: R.R. This 9-year-old child was referred by the parents because of extreme nervousness, stuttering, and the onset of facial grimacing. He was the elder of two siblings and the younger child was a newborn. A physical examination revealed a well nourished, well developed, white male and it was noted during the examination that there was evidence of stuttering and peculiar facial grimacing which were less apparent when the parents were removed from the room. This child was doing poorly in school and it was attributed largely to stuttering. Electroencephalogram and other laboratory studies were negative. The child was placed on hydroxyzine syrup, one teaspoon three times a day. The drug was readily accepted. On the questionnaire the parents reported that the child slept quietly at night, showed a markedly improved appetite, and was much less irritable and nervous. The teacher reported that the child no longer stuttered as badly while in school and it was the impression of both teacher and parents that there was improvement, although not complete relief of the symptoms. The parents rated this medication as a valuable aid and adjunct in controlling the child's nervousness. No undesirable side effects were reported and complete blood studies were later reported as normal as was the electroencephalogram.

These are a few of the cases showing a striking response to this medication. Of the 58 cases in which the medication was used, a number failed to respond satisfactorily or at all to the medication. When there was improvement, however, the response was dramatic.

The evaluation of any medication designed to assist in the management of behavior problems should be done on an individualized basis as we are treating a complex variety of symptoms in which the exact etiology is unknown. Atarax® syrup appeared to be indicated when used on an individualized basis and with discretion, in an attempt to control youngsters with severe or mild behavior problems.

The 58 cases in which the drug was used ranged in age from 2 to 16 years and the dosage from 2-6 teaspoonfuls (20-60 mg.) daily. All the patients were observed at regular intervals in the office and the parent in each case was ques-

tioned concerning the effect and apparent action of the drug.

In only a few instances was there rejection of the drug on the part of the patient, based on palatability. The undesirable side effects were negligible with only an occasional complaint of drowsiness. Blood studies done prior to institution of therapy and following several weeks on the drug showed no change and other studies done after several months of usage in some patients again showed normal laboratory results.

The electroencephalographic tracings were not changed in any way by hydroxyzine syrup. It should be noted that during the use of this preparation we were impressed by the lack of toxicity and no adverse side reactions were reported.

CONCLUSION

Fifty-eight pediatric cases manifesting a variety of symptoms of emotional distrubances and behavior problems were studied and treated with a new preparation, hydroxyzine syrup. Response to this medication was individualized and a large majority of the patients showed striking improvement.

The value of this preparation rests in the fact that it may be used as a valuable adjunct in controlling and handling varied emotional problems in private pediatric and general medical practice. The investigators were iimpressed with the lack of toxicity and minimal side effects which were observed even after long-term use.

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Prophylactic antibiotics

Other factors being equal, the effects of prophylactic antibiotics, per se, in the prevention of postoperative complications were assessed in a group of 250 patients subjected to a variety of otherwise "clean" surgical procedures. In every type of operation the rate of local as well as systemic infection was many times greater in individuals who were given antibiotics without specific indication or laboratory control. Our own incidence of complications was five times greater in Group II (appendicitis, herniorrhaphy, cholecystectomy, hysterectomy). The obvious answer to these results can be found in the fact that operative complications do not fill the criteria mentioned at the outset of this review necessary to secure successful antibiotic prophylaxis. Certainly, postoperative infections are unpredictable in both location of occurrence and specific bacterial etiology, and it is this reason that defeats the purpose. Evidence is presented that antibiotics not only fail to prevent postoperative complications but in fact seem to predispose to an increase in postoperative infectious complications. Their routine use, therefore, is to be condemned. *David F. Kapp, M.D. Antibiotic Prophylaxis in Unpredictable Infections. Guthrie Clin. Bull. April* 1957.

A New Colorimetric Tablet Test in Screening for Proteinuria

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A TEST for protein is an important part of each routine urinalysis and is done in most multiphasic screening studies that include urine examination. Recently, a new colorimetric test for urine protein has been developed and made available. It is called Albutest† and possesses significant advantages in screening programs. It is completely disposable and can be applied directly to turbid urine, thus avoiding the centrifuging or filtering required with older turbidimetric methods. This study describes its performance in detecting proteinuria in a screening program.

METHODS

The screening program was carried out in a large university medical center. A receiving and testing station was set up in a hospital waiting room for the benefit of students and employees. Urine specimens were delivered to the testing station where both colorimetric and sulfosalicylic acid tests for protein were run on the samples as they were received. The work was done by a registered medical technologist. A confirmatory test by each method was applied to each urine that gave a positive reaction. In all instances, the confirmatory tests agreed with the original ones.

Albutest was carried out according to the directions:

1. Place tablet on clean surface and put one drop of urine on tablet.
2. After urine has been absorbed, add two drops of water and allow to penetrate before reading.
3. Compare color of tablet with the color photograph provided.

The color photograph shows reactions produced by a urine with a large amount of protein, small amount trace, and a negative or normal urine. After addition of the two drops of water the appearance of each tablet might be described as follows:

Amount of Protein	*Reaction on Tablet*
Large Over 100 mg.%	Dark blue spot
Small 20-100 mg.%	Light greenish blue spot
Negative 0-10 mg.%	No color or trace of green

A commonly used sulfosalicylic acid turbidimetric test also was done on all specimens. A small amount of 5% sulfosalicylic acid reagent was placed in a small test tube and an equal amount of urine added, the tube shaken gently and the amount of turbidity read immediately. The results were recorded as negative, trace, small, medium or large amount. The sensitivity of this test, when read under conditions of ordinary lighting, is such that 10 mg. of protein per 100 ml. of urine gives a trace reaction. The sensitivity of the colorimetric test is approximately the same.

RESULTS

Table 1 summarizes the results obtained with the 742 urines in this study. All urines that were positive with the sulfosalicylic acid test also were positive with Albutest. All urines negative with the sulfosalicylic acid method also were negative with the tablet test. Two urines gave trace reactions with the colorimetric test but since they were very turbid, a trace increase

TABLE 1
PROTEIN TESTS ON URINE FROM 742 SUBJECTS

	Reaction with Colorimetric Tablet			
	Negative	Trace	Small	Moderate
Sulfosalicylic Acid Test:				
Negative	707			
Trace		18	6	
Small			7	
Medium				2
Large				
Inconclusive (very turbid urine)		2		

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†Albutest is a registered trademark of Ames Co., Inc., Elkhart, Ind.

in turbidity could not be detected after addition of sulfosalicylic acid. A total of 35 urines were positive for protein.

DISCUSSION

The data of this study indicate that the colorimetric tablet gives results comparable to those with the established sulfosalicylic acid procedure, and the sensitivity and accuracy of the colorimetric tablet are adequate for this type of usage.

The simplicity and convenience of the disposable test are emphasized by the fact that this study was carried out in the waiting room of a large hospital. No facilities were available for washing glassware, centrifuging turbid samples, or disposing of solutions. In this respect it was comparable to many temporary screening operations. About one-tenth of the samples received were turbid and could not readily be evaluated by the turbidimetric procedure. Examination of these samples was accomplished using a blank tube containing urine and water alongside the tube containing urine and sulfosalicylic acid. Turbid urines were tested with no inconvenience by the colorimetric tablet test. This is emphasized by the two urines described in Table 1 which were not capable of evaluation by the turbidimetric procedure but had a trace of protein by the colorimetric test.

The colorimetric tablet test for protein can be run easily by an untrained person. Therefore, in a case such as suspected orthostatic albuminuria, the physician might provide the patient with several of the tablets and instruct him to test serial samples of his own urine.

SUMMARY

A simple colorimetric tablet test for proteinuria has been used in a screening study and its reliability found comparable to a sulfosalicylic acid procedure. The colorimetric tablet test was superior to the turbidity test since it was simple, disposable, and could be applied to turbid urines.

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Controlled fluoridation

Today only eight of the 18 cities in this country with over 500,000 population are not fluoridating. It is anticipated that most of these eight cities will institute fluoridation within the next several years. After that occurs, the rate of increase in the number of people drinking fluoridated water will depend largely on the rate of adoption in cities between 10,000 and 500,000 The lag in the smaller centers also may be overcome during the next several years because of the greatly reduced costs that are now possible, the present availability of simplified and accurate techniques for determining the fluoride content of water supplies, and the growing public acceptance of the measure throughout the country. *Status of Controlled Fluoridation in the U. S. 1945-56. Pub. Health Rep. May* 1957.

New Law in Illinois Affecting the Practice of Medicine

Mr. Walter L. Oblinger, Associate Counsel, Illinois State Medical Society.

The 70th General Assembly which adjourned June 29, 1957 enacted several pieces of legislation which will affect the practice of medicine.

ILLINOIS CORONER'S LAW

SB 63 proposed by the Illinois State Medical Society, passed by both houses and signed into law by the Governor on July 9, 1957 constitutes the first major change in the law since 1874. Specifically it redefines a coroner's case as (a) a sudden or violent death, whether apparently suicidal, homicidal or accidental, including but not limited to deaths apparently caused by or contributed to be thermal, traumatic, chemical, electrical or radiational injury, or a complication of any of them, or by drowning or suffocation; (b) a maternal or fetal death due to abortion, or any death due to a sex crime or a crime against nature; (c) a death where the circumstances are suspicious, obscure or mysterious or where, in the written opinion of the attending physician, the cause of death is not determined; (d) a death where addiction to alcohol or to any drug may have been a contributory cause; or (e) a death occurring without medical attention. If the death falls into one of these categories the coroner is directed to conduct a preliminary investigation into the circumstances of the death. He is also directed to notify a designated physician (preferably a pathologist) to investigate "either by autopsy or otherwise," the medical cause of death. You will note that the coroner has reserved to him the legal or non-medical responsibilities while the physician assumes responsibility for the medical cause of death.

The medical examination or autopsy must be conducted by a physician duly licensed to practice medicine in all its branches and wherever possible by one having special training in pathology.

The physician then makes his own inquiries and examination of the body where indicated. If at this point he can come to a determination of the cause of death he makes a report of his findings which is filed with the coroner and with the State Department of Health. If he cannot determine the cause of death and in addition (1) the circumstances of the death are suspicious, obscure or mysterious, (2) the coroner concurs with the physician that death cannot be determined definitely except by autopsy, then it becomes the duty of the coroner to order an autopsy.

Other provisions of the Act require a coroner's permit before cremation of the body; prompt notification of the coroner by persons in custody of the body *or by the attending physician;* and prompt release of the body to the next of kin upon completion of the coroner's investigation.

The coroner is only required to empanel a jury in cases of attempted suicide, homicide and accidental death.

The physician in Cook County will be appointed by the coroner while in downstate Illinois he will be appointed by the State Department of Health upon the recommendation of the coroner. The Act will be implemented by the State Board on Necropsy Service to Coroners which is expected to set up a regional system so that pathologists will become available to every county downstate. The Board is presently engaged in preparing manuals for the guidance of the coroner and the examining physician.

NEW LICENSING PROVISIONS

Under a new law which will become effective on July 1, 1958, every physician and other licensee under the Medical Practice Act will be required to re-register with the Department of Registration and Education and every two years thereafter and pay a fee of $6.00. This action was approved by the House of Delegates at the 1957 Annual Meeting. The purpose of the Act is to make information available as to

just how many doctors there are practicing in Illinois, their distribution and under what type of license they are practicing. The change should facilitate the enforcement of the Act and turn up unlicensed persons. The Department will publish an annual roster of licensed persons, including a list of licenses suspended or revoked, copies of which will be filed in the office of each county.

Under another section of the Act effective July 11, 1957, examination fees will be charged medical applicants as follows:

1. To practice medicine in all its branches, $50.00 (was $10.00).

2. To treat human ailments without the use of drugs, medicines or operative surgery, $35.00 (was $10.00).

3. To practice midwifery, $20.00 (was $5.00).

4. To practice medicine in all its branches or for drugless healing on reciprocity, $150.00; or if based on examination passed for admission to the Medical Corps of the U. S. Army, U. S. Navy or U. S. Public Health Service, $50.00 (none previously charged).

5. For any re-examination, special or supplemental examination, an additional fee in the amount of the initial fee charged.

In addition every person receiving his initial license (not a renewal thereof) shall pay a license fee as follows:

1. Under sections 1 and 2 above, $25.00.
2. Under section 3 above, $10.00.
3. Under section 4 above, $50.00.
4. For a State Hospital permit, $25.00.

The purpose of the changes in this Act is to provide additional funds so that the Medical Examining Committee can give better, more up-to-date type of examinations and to provide additional funds for better enforcement of the Medical Practice Act.

Under another Act, section 13a of the Medical Practice Act has been changed to give the Department of Welfare authority as need arises to transfer its medical practitioners from one hospital to another without the necessity for re-issuance of their licenses. The license, formerly known as a limited license is now called a State Hospital permit and should prove to be less confusing and to eliminate situations which have cropped up in the past where these medical practitioners were practicing medicine outside of the State hospital. Another provision of this Act codifies an existing policy of the Medical Examining Committee that these practitioners must have served a one-year's internship in an approved hospital.

NARCOTICS

This session of the legislature made sweeping changes in the laws pertaining to the use of narcotics and other dangerous drugs. The Uniform Narcotic Act was repealed and supplanted with an entirely new law. The definition of narcotic drugs was expanded to include Alpha eucaine; Beta eucaine; "Cannabis" and all parts of the plant "Cannabis Sativa L.," opium and its derivatives but excluding apomorphine or any of its salts; "Coca leaves" or any of its derivatives but excluding those which do not contain cocaine or ecgonine; "Isonipecaine" meaning the substance identified chemically as 1-methyl-4-phenylpiperidine-4-carboxylic acid ethyl ester or any salt thereof; "Methadon" meaning the substance identified chemically as 4-4-diphenyl-6-dimethylamino-heptanone-3 or any salt thereof; all parts of the plant of the genus Lophophora whether growing or otherwise; the buttons thereof, alkaloids extracted from any such plant or any of its derivatives; "Dromoran" meaning the substance identified chemically as dl-3-hydroxy-N-methylmorphinan, 1-3-hydroxy-N-methlymorphinan (except d-3-hydroxy-N-methlymorphinan), dl-3-methoxy-N-methylmorphinan, or 1-3-methoxy-N-methylmorphinan (except d-3-methoxy-N-methylmorphinan), or any salt thereof by whatever trade name designated; "Nisentil" meaning any substance identified chemically as d-l, 3-dimethyl-4-phenyl-4-propionoxy-piperidine or any salt thereof by whatever trade name designated; "Ketobemidone" meaning any substance identified chemically as 4-(3-hydroxyphenyl)-1-methyl-4-piperidyl ethyl ketone or any salt thereof by whatever trade name designated; and any other narcotic drugs added by rule of the administering agency.

Enforcement of the Act is given to a Division of Narcotics in the Department of Public Safety. Drug addiction is made a criminal offense punishable as a misdemeanor. Narcotic prescriptions can be given only on official prescription forms which are to be issued by the Division. These prescriptions are in triplicate and a doc-

tor may apply for 100 at a time at a cost of 1c each. The doctor must sign 3 copies, retain 1 and give 2 to the patient. The patient presents 2 to the pharmacist who keeps one and forwards one to the Division by the 15th of the following month. Stiffer penalties are provided including forfeiture proceedings for vehicles and conveyances used in the illegal traffic. Of importance to the physician is the fact that a special section is devoted to doctors, pharmacists and others who are made subject to penalties for violation of record keeping. Addicts may be committed until January 1, 1958 to the keeping of the Director of Public Welfare as their guardian and after that date to the Superintendent of Narcotic Control. These addicts are to be placed in governmental ageneies for care and treatment. When cured the guardian shall petition the committing Court for release on probation.

A physician may prescribe narcotic drugs to patients suffering from disease, etc., but only to an addict when the addiet is confined to a city of county jail, penitentiary or county or state hospital. Emergency prescriptions may be written in case of epidemic, accident or calamity, loss of life, intense suffering, on unofficial prescription blanks in triplicate specifying the reason therefor. Oral prescriptions may be made provided they are promptly reduced to writing by the pharmacist and written memorandum made.

Another bill redefines barbiturate to include compounds and mixtures of barbituric acid and provides that barbiturates and amphetamines can only be obtained upon a written prescription (not the official prescription).

OTHER LEGISLATION

Other legislation enacted this session included chemical tests for intoxicated drivers, paternity blood tests, permissive legislation to include dentists and chiropodists under Blue Shield contracts, and an appropriation of $150,000 to the State Department of Health to supply prophylactic medicines for prevention of rheumatic fever and rheumatic heart disease to medical indigents.

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Gall bladder malignancy

Evarts Graham stated in 1931 that prophylactic cholecystectomy in calculous cholecystitis was justified because of the incidence of carcinoma in gall bladder specimens (8.5 per cent in his series). The average reported incidence of carcinoma of the gall bladder in autopsy and surgical specimens is approximately two per cent. The combined incidence of complications of gall bladder disease is justification for urging cholecystecomy. This is true particularly in patients over 60 years of age in whom calculous cholecystitis and carcinoma of the gall bladder are found more frequently than in the younger age groups. Other diseases, however, may preclude safe surgery. *E. Lee Strohl, M. D. and Willis G. Diffenbaugh, M. D. Carcinoma of the Gall Bladder. Geriatrics. August* 1957.

COOK COUNTY HOSPITAL CASE RECORDS



Two Uncommon Causes of Abdominal Pain

Peter Beaconsfield M.D., and Herman A. Jacobson M.D., Chicago

Case One. A 32 year old female was admitted to Cook County Hospital on October 15th, 1956 complaining of postprandial abdominal pain. She had first experienced the pain early in September. The pain always occurred after meals, particularly heavy meals and was located in the epigastrium and left upper quadrant, radiating occasionally to the left shoulder and neck. It was not associated with any particular type of food, and was not accompanied by nausea, vomiting or belching. The pain was not severe in nature, but more of a steady dull ache, and always disappeared when the patient stood up. It was aggravated on lying down. When present it lasted between one and two hours after the intake of food. There was no nocturnal pain, it never occurred before meals, and was not relieved by antacids, antispasmodics or other medication. The patient stated that she had experienced no change in bowel habits, and there had been no loss of weight. She had no previous gastrointestinal or abdominal complaints.

In August of 1956, three weeks before the present symptoms first occurred, the patient was hospitalized because of a chest stab wound. The knife penetrated the thoracic cage in the mid-axillary line through the sixth intercostal space. On that occasion the patient made an uneventful recovery and the pneumothorax absorbed quickly. At the time of her discharge she was symptom free and her chest X-ray revealed no abnormalities.

On present admission the patient's physical examination showed no abnormalities except tenderness on deep palpation in the left upper quadrant.

Chest X-ray revealed an elevated left diaphragm. Barium meal was negative, but the report of the barium enema stated that the flow was interrupted at the level of the splenic flexure. Whether this interruption of the barium flow was due to herniation of the bowel through the diaphragm, or an organic lesion, could not be established.

The patient was operated on the 26th of October. The abdomen was explored through a left paramedial incision, and a traumatic diaphragmatic hernia was found just anterior to the spleen, measuring 4 cm. in diameter. The hernia opening was plugged by a small portion of the transverse colon and omentum, which did not actually protrude into the thoracic cavity. The hernia was easily reduced, and the opening closed by a Mayo type repair. The patient made an uneventful recovery.

From the Department of Surgery, Cook County Hospital, and the Chicago Medical School.

Diagnosis: Traumatic diaphragmatic hernia.

Case Two. A 27 year old female was hospitalized because of abdominal pain of 12 hours' duration. The pain had started in the umbilical region, and at the time of admission was located in the right lower quadrant. It was constant, moderately severe, and non-radiating in nature. The pain was aggravated when the patient moved, and was lessened when she bent over or flexed her knees towards her chest. The patient had experienced a transient episode of nausea but there was no vomiting. She had a normal bowel movement the morning prior to admission, and had no urinary symptoms or previous history of gastrointestinal disturbances. Her last menstrual period ended three days before present admission.

On physical examination her blood pressure was 120/80, pulse 88 and respiration 18 per minute. Her temperature was 99°F. The abnormal physical findings were confined to the abdomen. There was muscle rigidity in the lower quadrant with marked tenderness, but rebound tenderness was not present. The maximum point of discomfort was found to be between the superior iliac crest and the umbilicus. There were no palpable masses present. The rectal and vaginal examinations were negative.

The white blood count was 9000 with 81 per cent polymorphonuclear leukocytes. The preoperative diagnosis was acute appendicitis.

Through a McBurnie incision a normal appendix was removed. While exploring the abdominal cavity a mass measuring 2x3 cm. was located within the sheath of the rectus muscle. The McBurnie incision was closed and, through a small right paremedial incision, a large hematoma was evacuated from between the posterior wall of the rectus muscle and the sheath. The epigastric artery and its accompanying vein were ligated above and below the region where the bleeding occurred. The patient made an uneventful recovery.

Diagnosis: Spontaneous rupture of the epigastric artery.

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The prognosis of epilepsy

The prognosis of epilepsy is just what one finds and observes over a period of time. If there is an underlying disease, that disease will be overcome. If there is no evidence of progressive disease, one must follow the condition of the patient for two to three years to find out the essential trend of the malady. This will sooner or later establish itself and can be interpreted in terms of malignant, benign, or periodic forms. The response to such medication as we have is another factor. Generally speaking, a high degree of optimism should be embraced for it is easy to give up hope and quit. The best physicians I have found who treat the disease are filled with the sense of relativity. To them, a patient who is a total loss economically and a diffienlt member of the community is as far apart as worlds away from one who can support himself and his family, and still have epileptic fits. From that to the normal is only one step and this gap is adjusted to gratefully and wholeheartedly by those suffering from the Sacred Disease. *Harry Lee Parker, M. D. Clinical Studies in Neurology.*

CASE REPORTS



Vitamin D Intoxication

Neal Barnes, M.D., Springfield

THE toxicity of vitamin D, if given in sufficient dosage for a long enough period of time, is well documented.[1,2,3] It is regrettable that this danger is not universally appreciated by physicians and that it is almost unknown to the laity. Nevertheless, the lay public is able to obtain products containing large amounts of vitamin D on request. Vitamin D, in conjunction with calcium, has been advised for various arthritides in medical literature in the past[4] and even more currently in syndicated health columns.

A 67 year old white man was admitted to the hospital on February 12, 1956, for left inguinal herniorrhaphy. Routine admission laboratory studies revealed a hemoglobin of 9.1 grams per cent and erythrocytes, 3,500,000. Urinalysis was negative.

He had been treated for duodenal ulcer in 1946. Symptoms disappeared and he had little or no trouble with gastrointestinal symptoms afterward until May, 1952. Then epigastric distress recurred and bothered him frequently. He took large quantities of milk and aluminum hydroxide gel. On November 11, 1952, subtotal gastric resection was performed for massive gastrointestinal hemorrhage. A large benign gastric ulcer was found on the lesser curvature.

A right inguinal herniorrhaphy was performed on January 19, 1951. Shortly after this he complained of joint pains involving wrists, fingers, and shoulders. A diagnosis of rheumatoid arthritis was made and he was treated with ACTH. The early response was good. Therapy was changed to cortisone but this was discontinued after a few weeks "because of glycosuria."

From 1951, until this admission his joint complaints had been variable but almost constant and deformity had been progressive. The feet and ankles became involved. During 1950, firm and non-tender nodules, measuring from 0.5 to 2.0 centimeters appeared over the extensor surfaces of the toes, fingers, elbows, wrists, and Achilles' tendons. A few of the nodules had drained spontaneously, discharging a thick milky material. Aside from the joint abnormalities physical examination was within normal limits. The hemoglobin measured 9.1 grams per cent; erythrocytes were 3,500,000; white cell count, 8,000 with a normal differential. Blood urea nitrogen was 9.1 milligrams per cent and uric acid 4.06 milligrams per cent. The stools were negative for occult blood and complete gastrointestinal X-ray studies were negative. After one month on ferrous sulfate therapy, hemoglobin increased to 11.0 grams per cent and erythrocytes to 4,480,000. The stools were negative for occult blood. A left inguinal herniorrhaphy was performed and followed by an uneventful recovery.

On June 6, 1956, the patient was readmitted on the urologic service in a semi-stuporous state.

His wife said he had been bothered by urinary frequency and nocturia for two years and that for the past three months there had been a gradual increase in lethargy. More recently he appeared confused. During the few days prior to admission he slept for long periods. The urologist found no evidence of urinary tract disorder and the patient was transferred to the medical service.

Except for moderate pallor, the nodules on the extremities were the only remarkable physical abnormalities. Neurological examination revealed nothing unusual. The blood pressure was 110/70. Temperature was 98.4 degrees; pulse, 80. Initial and subsequent laboratory values are presented in Table 1. An electrocardiogram taken on February 3, 1956, showed sinus tachycardia with a rate of 110; otherwise the tracing was within normal limits. The Q-T segment measured 0.34 seconds. An electrocardiogram of June 15, 1956, showed a sinus rhythm of 90, Q-T segment 0.28 seconds, low voltage of all QRS segments and low T-1. On June 16, 1956, the quantitative 24 hour urinary excretion of calcium was 578.4 milligrams. Calcium intake had been limited to 150 milligrams daily.

Further exploration of the patient's history with his wife brought out that he had been taking vitamin D and calcium on the advice of an arthritic friend. She thought he had been using this medication for three months or longer. The intake of calcium consisted of one quart of milk and 12 grams of calcium lactate daily. The daily intake of vitamin D was 300,000 units. Roentgen examination of the chest and bones showed no abnormality other than scattered calcifications in the left upper abdominal quadrant. These calcifications were not in the kidney.

Treatment consisted of parenteral fluids, tube feedings of low calcium content, and whole blood transfusions to a total of 4,000 cc. Intake was patterned to the laboratory values and to the daily urine output, which varied from 1,200 to 1,800 cc. Over a period of two and one-half weeks the patient improved gradually; stupor was less conspicuous and he took a soft low calcium diet of approximately 1,500 calories. On June 26, 1956, the tip of the spleen was palpable for the first time. On July 1, 1956, he appeared more stuporous than he had been and the urine became dark brown. On July 2, 1956, he was icteric. He became comatose and more deeply jaundiced and on July 4, 1956, he expired. Permission for autopsy was refused.

COMMENT

Failure to obtain autopsy permission prevents exclusion of primary hyperparathyroidism as a diagnostic possibility. The evidence supports a diagnosis of hypervitaminosis D. A past history of peptic ulcer and the existence over a period of time of moderate anemia are suggestive of primary hyperparathyroidism.

The absence of intestinal complaints after partial gastrectomy is not in accord with most reports on peptic ulcer surgery that is associated with hyperparathyroidism.[5] Gutman et al[6] first called attention to gastrointestinal symptoms in primary hyperparathyroidism. A later comprehensive study of hyperparathyroidism by Black[7] clarified the upper intestinal symptomatology of this condition. Black found clinical evidence of peptic ulcer in 24 per cent of patients with hyperparathyroidism and ulcer-like symptoms in 15 to 20 per cent more. In the patient reported here, the serum phosphorus and alkaline phosphatase values and the absence of skeletal changes[8,10] are of little help in differentiation. Phosphatase and skeletal changes would be unexpected in a patient of this sort with a high calcium intake.

Differentiation between hyperparathyroidism and the Burnett Milk-Alkali-Syndrome often is difficult and even impossible clinically.[9,10] In this case Milk-Alkali-Syndrome is not a diagnostic problem because at no time was there a history of ingestion of large amounts of absorbable alkali. Futhermore, the marked acidosis and hypercalciuria eliminate it from further consideration.

The antirachitic effect of vitamin D was established by McCollum in 1922[8] when he separated this fraction from the vitamin A of cod liver oil. The same properties were found later in ultraviolet irradiated ergosterol. Subsequent purification resulted in vitamin D^2, or calciferol. If an adequate dietary intake of calcium and phosphorus is provided, vitamin D has a curative effect on rickets and osteomalacia, both of which develop as a failure of ossification of osteoid. Vitamin D exerts its influence by increasing the absorption of calcium from the upper intestinal tract. There is a resultant ab-

TABLE 1

Date	NA	K	Urine				HGB.	RBC	HCT	WBC
	MEQ/L	MEQ/L	Sp. Gr.	Alb.	Sug.	Micro.				
6-6 -56			1.010	0	0	8-12 hyal. casts	7.9	2.01		4,050
6-11-56							9.5		28	
6-13-56							9.5		28	
6-14-56										
6-15-56										
6-16-56									30	
6-17-56	131.7	4.74								
6-18-56			1.010	0	0	30-40 WBC 40-50 RBC				
6-20-56									29	
6-22-56										
6-24-56			1.010	0	0	10-12WBC 20-30RBC				
6-25-56										
6-26-56									37	
6-27-56	130.4	4.7					11.0	3.81		7,300
7-2 -56			1.011	+	0	2-4 gram. bil. + 8-12WBC 8-16RBC Urob 1:200				
7-3 -56										
7-4 -56	132.6	4.3								

sorption of phosphorus lower in the small intestine.[11] A lesser influence of vitamin D is that of increasing the renal excretion of phosphorus by decreasing its reabsorption in the tubules. A daily intake of 400 units of vitamin D is more than adequate in normal infants and adults.[8] The administration of vitamin D is followed by an early rise in the serum calcium and phosphorus. Later there is inhibition of the parathyroid glands, with a decrease in the renal phosphorus excretion. In a normal person on a diet limited to 150 milligrams of calcium in 24 hours there is an excretion of 100 to 200 milligrams in the urine in 24 hours and 300 to 400 milligrams in the stool. An increase in the dietary calcium is reflected mainly as increased excretion in the stool.

The degree of toxicity of vitamin D is variable. The shortest time reported is 12 days[12] at a dosage of 750,000 units a day. Most reports in the literature show an intake over a period of months or years. The toxicity of vitamin D is considerably increased in proportion to calcium intake. In the case presented here the period over which excessive doses of vitamin D are known to have been taken is shorter than most, but is quite sufficient for an advanced state of intoxication.

The admitting picture in this patient was considered as due to hypercalcemia of vitamin D intoxication. Chaplin et al.[13] have described these symptoms as weakness and fatigue with weight loss, nausea, vomiting, cramps, diarrhea, headache, paresthesias, vertigo, mental depression, urinary frequency, nocturia, and abnormal calcifications. Scharfman and Propp[14] stressed the importance of normocytic, normochromic anemia in these patients. They were of the opinion that the anemia is due to azotemia. This, however, is a matter of conjecture, particularly in view of the reported response of the anemia to iron therapy.[3] Extensive neoplastic metastases to bone is eliminated by virtue of their failure to appear on an X-ray survey.

The appearance of jaundice and the rapid downhill course in the past few days of this patient's life are open to question. Terminal fulminating hepatitis seems likely, although thrombosis of the portal and splenic veins deserves consideration.

Although adequate and repeated warnings of the danger of the ill advised use of vitamin D

TABLE 1 (Continued)

Diff.	FBS	NPN	BUN	CO_2	CA	P	Alk. Phos.	Ser. Bil.	Ser. Prot.	Ceph. Flocc.	CL.
	MGM%	MGM%	MGM%	MEQ/L	MGM%	MGM%	BU	MGM%	MGM%		MEQ/L
P76 L24	97	61.6									
			53.2	17	13.5	4.40	4.66				100.2
								D .44 I .66 T1.00	T6.59 A4.03 G2.56		
			48.1		15.06	4.4					
			64.2		13.1	4.4					
			68.1								
			64.5		13.7	4.48					
P64 L36											
								D13.2 I 1.4			
			49	18.3	13.8	4		T14.6			

have appeared in the literature for almost 30 years, this continues to be a real and probably not rare problem. It is wise to inquire in detail about the medications patients are taking. An innocuous history of taking "vitamin pills" may have considerable significance.

SUMMARY

A fatal case is presented involving the ingestion of large amounts of vitamin D in association with a high intake of calcium. Postmortem examination could not be made. The clinical evidence, however, points most strongly to vitamin D intoxication as the cause of death.

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EDITORIALS

Drugs, stock brokers and editors

Times are changing. Nowadays, stockbrokers are better informed than physicians on new developments in the drug industry. Pharmaceuticals are big business and the announcement of a new product often is made for the benefit of stockholders. The slightest suggestion of a promising newcomer will shoot the company's stock to a new high. These changes are not always appreciated by the medical profession.

Physicians no longer are the sole disseminators of information on new drugs and procedures; this information is considered news and is handled by those who deal in mass communication. On the other hand, many of our newspapers, magazines, and radio and television services are overlooking the wealth of experience accumulated by the medical profession concerning releases on new drugs. Some newspapers, for example, are exploited by the public relations departments of large pharmaceutical companies, which submit biased claims on the value of new products long before they have been tested properly. These claims are accepted as the gospel truth and make sensational stories.

Most of this information should be turned over to the newspaper advertising department, where it belongs. On the other hand, the direct appeal to the public has many advocates. Mass inoculation of millions of Americans with the Salk vaccine is an example. Organized medicine moved too slowly for the National Foundation of Infantile Paralysis.

We object, however, to the airing of controversial matters in the press by competing organizations. The National Health Education Committee sent out a long news release headed *"T. B. Expert Says Medical Profession Fails To Use Proven Vaccine Despite Continuing High Incidence Of Disease In The United States."* In smaller print, we find: *"Dr. Riggins urges BCG in infants to speed elimination of t.b."*

Ten days later came a release from the Bureau of Industrial Service: *"South American Physician Says Experimental TB Vaccine has Distinct Advantages over Present BCG Type."* The medical profession was not scooped on this new vaccine; the story appeared in the June issue of the American Review of Tuberculosis and Pulmonary Diseases. The experimental vaccine is a Parke-Davis product and it is difficult to understand why it was announced this way. Your editors have not inquired but we might use the new excuse — the stockholders are interested.

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Voluntary allocation plan for flu vaccine

A voluntary allocation program similar to the Salk poliomyelitis vaccine plan of last year has been placed in effect by the six manufacturers of the Asian influenza vaccine. The U.S. Public Health Service, in making the announcement,

said the firms had agreed to allocate supplies among the states according to population. The Public Health Service said it was endorsing the State and Territorial Health Officers' recommendation that the states and communities set up advisory committees to determine who should receive vaccine first. P.H.S. has suggested first priorities for persons providing medical care and those maintaining essential services.

On the state allocations, manufacturers will report weekly to P.H.S. the net amount of vaccine released for sale that week and, on a state-by-state basis the amount shipped to public agencies and other purchasers. P.H.S. will recommend changes in allocations if it appears that supplies are exceeding demands in some states. Under this plan, Illinois will receive 5.5% of the vaccine as it is released. New York will get 9.5%, California 7.9% and Pennsylvania will receive 6.4%.

The AMA special committee on influenza headed by Dr. Harold Lueth of Evanston, has co-operated closely with the Public Health Service and is in full agreement with the voluntary allocation system as initiated by the P.H.S. This committee is preparing two special reports covering the Asian influenza situation, which will be published in early issues of the JAMA.

All age groups are susceptible to influenza, and the vaccine is recommended for all persons with the exception of those suffering from allergy to egg protein. Limited experience with adult volunteers has resulted in few reactions, all of which have been mild. Reactions have been reported among a very few young children and it seems that children generally have more severe reactions to the vaccine than adults do.

With respect to complications following influenza, it also has been observed that infants under one year of age are more liable to these complications. The same applies to persons with chest conditions, such as tuberculosis or pulmonary emphysema, cardiovascular illness, or diabetes. Particular emphasis should be given to early vaccination of these persons as the vaccine becomes available.

No known medicine will cure influenza. The sulfonamides and penicillin or other antibiotics have no effect on it, although they are used to combat some of the complications. The only medical preventive of practical value known to medical science is influenza vaccine. It should be kept in mind that the new vaccine is different from that previously used. The immunity response does not develop immediately but takes from 10 days to two weeks.

In all Illinois communities, city and county officials, public health officers and members of the county medical society will develop local plans for the use of the new Asian influenza vaccine.

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Nonservice disabilities

The following editorial from the Phoenix, Arizona, *Republic* points up our attitude toward the treatment of nonservice connected disabilities in our veterans hospitals:

"John F. Burke, of Bayonne, N.J., is the cheerful articulate commander of the nearly 200,000 members of the Disabled Veterans of America. He lost an arm at Monte Cassino and took enough lead in the rest of his body to have killed most people. He draws 100 per cent disability pay from the government, and no one could possibly begrudge him a cent of it. So long as Commander Burke advocates a square deal for veterans who were wounded in battle or whose health was destroyed during the war, we think he is on firm ground. But when he rambles off into the by-ways of socialized medicine, federal aid to education, and a general exposition of the philosophy of an all-wise, all-generous centralized government — as he did at a Phoenix Press Club forum this week — we think he is way out in left field.

"Mr. Burke was asked specifically whether he thought the veterans hospitals should treat veterans with nonservice connected disabilities. His answer was an emphatic 'yes' so long as the veteran qualified from the standpoint of not being able to pay for the medical or surgical service in a regular hospital. His reasoning was that such an indigent would require hospitalization anyway and it didn't matter whether he got it in a city, county, or federal hospital. Much as we hate to disagree with a man who has demonstrated his patriotism as Mr. Burke has, we think he is completely wrong. He is wrong because nonservice connected disabilities are no concern of the federal government. If the U.S. Treasury is expected to provide medical care for a veteran who falls out of a second story window

20 years after a war is over, then it should be expected to pay for the care of every citizen who falls out of a second story window. And that is socialized medicine, any way you look at it.

"Veterans hospitals have no medicines or techniques not available to all hospitals. They can't care for a patient better than other hospitals. They do have a call on the apparently inexhaustible tax dollars of the nation, thanks to one of the best organized lobbies in Washington. But those tax dollars come from all over the nation. There is no money tree in Washington. The federal government gets money to run hospitals in exactly the same way that local units of government get it. Actually, the dollars shrink as much as 33-1/3 per cent on the round trip to and from Washington. Local units of government, to say nothing of local charitable organizations, can and should take care of indigents, veterans and nonveterans alike, when they become injured or sick. To say that the veteran deserves special care in federal hospitals for illnesses or injuries in no way connected with military service is to say that the veteran is a privileged citizen. We don't believe the average veteran feels that way about it, and we think Mr. Burke is making a mistake in mixing up socialized medicine and aid to schools with the legitimate needs of the disabled veterans."

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Dedicate addition to sanatorium

On Sunday, August 18, Governor Stratton dedicated the new 50 bed addition to the State tuberculosis sanatorium at Mt. Vernon. He hailed the program of education over the years "which took tuberculosis out of the mystery of the dark ages and subjected it to the enlightenment of modern civilization and science."

The Governor declared that while great progress has been made against tuberculosis, it is far from over. "Ahead lies many more years of work in using the tools we have developed to wipe out eventually the threat of tuberculosis to the human race."

Dr. Roland R. Cross, Director, State Department of Public Health, hailed the Mt. Vernon sanatorium as "an unexcelled example of the type of hospital care that is needed to cope successfully with the sickness caused by tuberculosis." Dr. Cross stated that since the Mt. Vernon hospital was opened six years ago, it has been operating at almost maximum capacity. Up to June of this year, 1,393 patients had been admitted to the sanatorium as bed patients. Of these, 920 had been discharged as entirely well, or greatly improved. Of the number of patients admitted, 791 were given surgical treatment.

Dr. Andy Hall told of the great progress made in reducing deaths from tuberculosis. Senator Paul Broyles, who acted as master of ceremonies, in introducing Dr. Hall lauded him as the head of two committees that originally sought a tuberculosis sanatorium for Southern Illinois, and then chose Mt. Vernon for its location. Governor Stratton paid his respects to Andy Hall and Roland R. Cross for their pioneering work in getting the sanatorium and their great interest in the control of tuberculosis.

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Plans for the 1957 AMA clinical meeting

Plans are under way for the 11th annual clinical meeting of the American Medical Association, to be held in Philadelphia, December 3-6. Center of activities will be the convention hall where scientific exhibits, color television, motion pictures, technical exhibits, and scientific lectures will be presented. Headquarters for the House of Delegates will be the Bellevue-Stratford hotel, where the sessions will be held.

The clinical session is geared especially to the family doctor and will include:

(1) A special transatlantic conference between distinguished physicians in London and Philadelphia. They will talk on "Advances in Chemotherapy of Cancer" via two way telephone at 3 p.m. Wednesday.

(2) Complete color television schedule of surgical demonstrations emanating from Lankenau Hospital.

(3) Daily motion picture program plus a special session on Tuesday evening.

(4) Exhibits featuring a program and special displays on the history of medicine in the Philadelphia area, fractures, and manikin demonstrations on problems of delivery.

(5) Panel discussions on cardiovascular disease, cancer, emotional problems of the menopause, hypertension, diabetes, arthritis, and traumatic injuries.

(6) Selection of the General Practitioner of

the Year, who will receive an award at the session.

The complete program will be available soon through the JAMA, and many Illinois physicians will be looking forward to attending.

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I.S.M.S. postgraduate conferences

The State Society Committee on Postgraduate Medical Education and Scientific Service is now arranging the schedule of conferences to be held in various parts of the state, beginning in September. Programs given by teams from the medical schools and larger hospitals are being arranged for the general practitioner.

These P.G. conferences have been conducted by the Illinois State Medical Society for approximately 20 years. An effort is made to avoid conflicting meetings which might lower attendance and it is hoped that physicians attending the meetings will arrange to participate in the discussions. The speakers selected for the conferences must leave their busy schedule for at least a day to make their presentations, and it is hoped that during the current schedule, the attendance will be better than in the past.

The Committee is desirous of scheduling more of the circuit rider type conferences in smaller communities, as they have been quite popular in the past. It is the usual custom to schedule these meetings in a hospital, and one clinician will present the program by looking over case histories, laboratory findings, and other available clinical data, then discuss the management of the patient. Physicians prepare in advance for the presentation of cases and material to make them more interesting. It may be possible for one clinician to appear in two or more communities on consecutive days if so desired.

Societies interested in this type of program may get additional information by writing to Dr. Louis R. Limarzi, Chairman of the Committee on Postgraduate Medical Education and Scientific Service, Suite 1909, 185 N. Wabash Ave., Chicago 1, Illinois.

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Food for thought

Medicine may hopefully have more time to think about the quality as well as the quantity of living. More than occasionally one hears the half-complaint: Physicians have lengthened living without increasing enjoyment. Can physicians, for patients and for themselves, give a little more sense of direction at this point? Life itself frequently can be preserved or at least defended from the outside: pleasure in living is something that can best be protected by internal resources. Physicians need more awareness of this but as one said the other day, "It seems that some patients won't face the fact that the only way to live a long time is to get old." What will the physician's life be like when the expectancy is 90 years and retirement starts at 50? *Editorial. How Many People? Med. Science. July* 10, 1957.

THE P. R. PAGE

Edward A. Uzemack, Director of Public Relations

DR. RALEIGH C. OLDFIELD, president-elect of the Illinois State Medical Society, last month became the first physician in the nation to receive the official emergency call credential of the National Police Officers Association of America.

The credential, an attractively designed automobile visor card, is intended to provide a national standard for identification of physicians on emergency call, civil defense or disaster duty.

In accepting the first card from Frank J. Schira, president of NPOAA, at the Association's second annual meeting in Chicago, Dr. Oldfield said:

"In co-operating with your organization to produce this automobile visor identification card, the American Medical Association recognized the value of quick and positive recognition of the physician's automobile during an emergency. Your officers and board members are to be congratulated for originating the idea of a standard, nationally distributed card such as this one.

"This occasion is significant in that it pays homage to the co-operation which has been traditional between the medical and law enforcement professions in this country. I feel that it will spark an even greater degree of co-operation between doctors and police officers in communities throughout the United States."

Emergency call credentials have been distributed by county medical groups in the past, but there has been no uniformity of design or effective safeguards against abuse. The NPOAA card has to be renewed yearly and must be countersigned by the local police commander or chief of police.

There is a charge of $1 a year for the card. This fee covers the cost of printing, mailing, and administrative control of the card system by the NPOAA. The cards may be obtained by writing to Secretary, Police Surgeons Committee, National Police Officers Association, 100 West Chicago Avenue, Chicago 10, Illinois.

Doctors and Horses

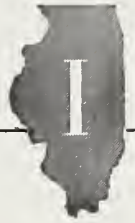
A revision of the popular "Doctors and Horses" booklet has been completed by the Committee on Rural Health and Student Loan Fund. Committee Chairman Harlan English expects to announce the distribution date soon.

The 24-page booklet was revamped from cover to cover. New sections which had to be included since the last printing cover the Physician Placement Service, Postgraduate Education Conferences and the Illinois Health Improvement Association.

Divided into two parts, the first portion of the booklet deals with activities which the Illinois State Medical Society and the Illinois Agricultural Association perform for people in rural areas. The second part deals with the things that these same people can do for themselves.

(*Continued on page* 195)

CORRESPONDENCE



State health department needs four P. H. physicians

The State of Illinois is seeking four Public Health Physicians to administer high-level programs in its Department of Public Health. One will be employed at Carbondale, as Regional Health Officer for the Southern Region of the State. The other three physicians will work at Springfield. One of these will be Medical Assistant to the Deputy Director of the Department who has charge of the Division of Local Health Services. A second will serve as Chief of the Bureau of Communicable Disease Control. The third will be Chief of the Bureau of Geriatrics, in the Division of Hospitals and Chronic Illness.

Salary range for these positions is $7490.00-$9150.00. The merit examination consists of a written test and an oral interview. These will be held in Springfield and Chicago, and can be administered in other locations, to accommodate the convenience of candidates. Transportation for an employment interview may be paid.

Applicants should be graduates of an approved medical school, with a year of rotating internship in an approved hospital, and a year of graduate training in public health medicine and administration. They must be eligible to obtain an Illinois license. In addition they should have four years of public health experience in a responsible administrative position, and one year of experience in the general practice of medicine or as a resident in an approved hospital.

Interested persons should contact the Illinois Department of Personnel, 121 State House, Springfield, or Room 1800 Illinois Building, Chicago.

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Clinics for crippled children listed for November

Twenty five clinics for Illinois' physically handicapped children have been scheduled for November by the University of Illinois, Division of Services for Crippled Children. The Division will count 20 general clinics providing diagnostic orthopedic, pediatric, speech, and hearing examination along with medical social and nursing service. There will be 3 special clinics for children with cardiac conditions, 1 for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in co-operation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

The November clinics are:

November 5 — Casey, Casey High School

November 5 — Macomb, Marietta Phelps Hospital

November 5 — Pittsfield, Illini Community Hospital
November 6 — Fairfield, Fairfield Memorial Hospital
November 6 — Hinsdale, Hinsdale Sanitarium
November 7 — Litchfield, Madison Park School
November 7 — Sterling, High School Field House
November 8 — Chicago Heights [Cardiac], St. James Hospital
November 12 — E. St. Louis, St. Mary's Hospital
November 12 — Peoria, Children's Hospital (St. Francis)
November 12 — Shelbyville, Methodist Church
November 13 — Joliet, Will County T.B. Sanitarium
November 14 — DuQuoin, Marshall-Browning Hospital
November 14 — Springfield, St. John's Hospital
November 14 — Watseka, American Legion Hall
November 19 — Alton, Memorial Hospital
November 20 — Elmhurst [Cardiac], Memorial Hospital of Dupage Co.
November 20 — Evergreen Park, Little Company of Mary Hospital
November 20 — Springfield (Cerebral Palsy), Memorial Hospital
November 21 — Decatur, Decatur-Macon County Hospital
November 21 — Rockford, St. Anthony's Hospital
November 22 — Chicago Heights [Cardiac], St. James Hospital
November 26 — Effingham (Rheumatic Fever), St. Anthony's Hospital
November 26 — Peoria, Children's Hospital (St. Francis)
November 27 — Aurora, Copley Memorial Hospital

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Conference of state mental health representatives

The fourth annual conference of the mental health representatives of the various state medical associations will be held on November 22 and 23. The conference, which is sponsored by the AMA Council on Mental Health, will be at the Drake Hotel, Chicago.

Two fellowships to recruit workers in audiology and speech

Establishment of two fellowships in Audiology and Speech at Northwestern University is announced by the American Hearing Society, its member agency, the St. Paul Hearing Society, and the university. The new training program will be geared to preparing qualified persons for work in local hearing societies.

The fellowships, made possible by a bequest from the Myers Foundation of St. Paul, Minn., are to be known as The Reine Humbird Myers Fellowships. Each fellowship will pay $3,000 a year for two years.

Applicants may write to Crayton Walker, executive director, American Hearing Society, 1800 H St., N. W., Washington 6, D. C., or to Dr. Raymond Carhart, School of Speech, Northwestern University, Evanston, Ill.

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American College of Surgeons sectional meetings

All members of the medical profession are invited to attend the following 1958 sectional meetings of the American College of Surgeons being held in conveniently located cities of the United States, with one supplementary meeting in Sweden.

Meeting cities and dates follow:

DALLAS, TEXAS, January 9-11.
JACKSON, MISSISSIPPI, January 16-18
NEW YORK CITY, March 3-6
SALT LAKE CITY, UTAH, March 17-19
DES MOINES, IOWA, March 27-29
STOCKHOLM, SWEDEN, July 2-7.
CHICAGO, 44th annual Clinical Congress, October 6-10.

All sectional meetings draw on surgeons of outstanding ability to discuss problems encountered in daily practice, and to disseminate information about new techniques. Usefulness is the keynote to all College programs, which are planned by local committees answering the needs and wishes of doctors within the meeting area. Panels, symposia, papers, medical motion pictures, and question and answer periods characterize the meetings.

Two new features are scheduled for each sectional meeting this year: a fellowship luncheon, at which a panel of college officials will

answer questions about the entire program of college activities, and, in turn, pose questions to the audience; and a social, rather than scientific, dinner meeting, to which program participants, visiting surgeons, wives and other guests are cordially invited for an informal and pleasant evening of entertainment.

Detailed information will be released well in advance of each meeting. For any additional information, write to Dr. H. Prather Saunders, Associate Director, American College of Surgeons, 10 East Erie Street, Chicago 11, Illinois.

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A welcome gift

Now is the time to think of Christmas gifts to avoid the rush that is characteristic of the season. Please include in your list VOLUME II of the History of Medicine in Illinois. This volume has interesting reading material which physicians particularly will appreciate. It is a life-time gift and a memento of the inheritance of the doctors practicing medicine in Illinois today. It is a suitable gift to hospital libraries, medical students, interns, residents, practicing physicians, specialists and to laymen interested in the practice of medicine in Illinois. The price is $10.00 and copies may be obtained by writing directly to the Secretary, Illinois State Medical Society, Medical Arts Building, Monmouth, Illinois; or to 185 N. Wabash Ave., Chicago, 1, or by getting in touch with Mrs. Manuel E. Lichtenstein, 1400 N. Kedzie Avenue, Chicago 51, Illinois.

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Symposium on fluorides

The Institute of Industrial Health at the College of Medicine of the University of Cincinnati announces a three-day Symposium on Fluorides to be presented December 9-11, 1957 inclusive. The purpose of this symposium will be to present the most recent information that is available concerning the physiological behavior of the absorption of fluoride.

Discussions will include a brief review of what is known of fluoride metabolism and a considerable amount of data that have hitherto been unreported. The objectives of the symposium are to bring together and to present factual and scientific information on this subject to those who are working in the field of fluoride absorption.

The symposium will be open to physicians and dentists in industry and public health and to other professional persons. Attendance will be limited and early application is suggested. The registration fee will be $50.

For further information and application blank write to Secretary, Institute of Industrial Health, Kettering Laboratory, Eden and Bethesda Avenues, Cincinnati 19, Ohio.

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Volume 2 of Bibliography of Medical Reviews

Thirteen months after the publication of the experimental *Bibliography of Medical Reviews*, 1955, Volume 2 made its appearance in August. In the interim, ample evidence of its acceptance was accumulated to warrant the continuation and expansion of the venture as a regular annual publication of the National Library of Medicine.

The 1500 copies of Volume 1 were quickly distributed within the first few months and requests continued to be received right down to this writing. This time almost twice the number of copies were printed and sufficient supplies should be available from the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at 60 cents per copy.

The internal format and arrangement of the second volume remain about the same as before. Complete entries, including the bibliographic reference and translation of foreign title, appear under the various subject headings derived from the *Current List of Medical Literature Subject Heading Authority List;* cross references are not restricted to those in the *Authority List* but are provided generously. The overall size of the issue is substantially greater with about 1800 review articles cited as compared with 1100 articles in Volume 1. In both volumes, all material was culled exclusively from journals indexed in the *Current List of Medical Literature*. The collection basis for *Bibliography of Medical Reviews III* has been broadened to include review articles published in journals which are not already indexed in the *Current List of Medical Literature*. Consequently, the next volume will show a further increase in size as well as other format changes, including the provision of an author approach to the material.

AT THE EDITOR'S DESK



THE Gillette Company is getting into the pharmaceutical business via a newly created division — Gillette Laboratories. This is a plan to hedge against recessions in such lines as razor blades and Toni home permanents. Arrangements have been made with Upjohn to use their research and technical know-how in preparing a line of proprietary drugs. No existing Upjohn products are involved at present. There are rumors that Gillette's first drug will be a proprietary cough and cold preparation.

Prentice-Hall, Inc., New York publishers, have sent out a news release on Dr. Frank S. Caprio's new book, Helping Yourself with Psychiatry. Dr. Caprio's technique for self-analysis is stressed and the method is said "to solve personality defects that lead to such personal tragedies as divorce, nervous breakdown, alcoholism, and sexual maladjustment." This is a new do-it-yourself field and we wonder how successful it will be. More and more persons are getting tired of doing things for themselves; they want others to do it for them.

Warner-Chilcott Laboratories have developed a simple test for liver and bone disease. A few drops of blood serum are added to a reagent tablet (Phosphatab), a color developer is added, and diagnosis is made by comparing the color of the mixture with a color chart. The test is said to be of value in all types of liver disease, including stones in the common bile duct. The release says the technique will disclose metastases to the liver, pancreas, and bone. The same company offers Sterisil, which is said to cure the common types of vaginitis, including the trichomonal and monilial varieties.

Bendectin is Merrell's new medication to relieve nausea due to pregnancy and motion sickness. Symptomatic relief was obtained in 179 of 205 patients.

McNeil Laboratories have combined Flexin, a muscle relaxant, with Tylenol acetaminophen, an analgesic. The combination will be marketed as Flexilon.

Upjohn has signed a contract to provide rare and commercially unobtainable steroid hormones to the National Cancer Institute. Some of the newcomers include Medrol, their potent cortical hormone, and Halotestin, a male sex hormone used for palliative treatment of female cancer of the breast.

It is not generally realized that the federal government has gone into drug and medical research in such a big way. For the year starting July 1, the National Institutes of Health will have a medical research budget in the neighborhood of $200 million; VA, $11 million and the National Science Foundation, $40 million. Many

other agencies and bureaus also are involved in medical research through grant programs.

By utilizing transistors, the Sanborn Company was able to make an electroeardiograph the size of a brief case, weighing only 18 pounds.

VA treated only nine cases of malaria during the first three months of 1957. Credit for the tremendous drop in the incidence of this disease goes to primaquine and chloroquine. Hundreds of thousands of veterans contracted malaria overseas during World War II and the Korean conflict.

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THE P.R. PAGE (Continued)

Taking a bow —

Just to prove that PR Directors are bigger hams than other people, I take the liberty of quoting the following letter addressed to the PR Director of the ISMS by Leo E. Brown, PR Director of the American Medical Association:

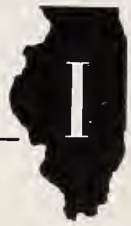
"Dear Ed:

"If AMA were handing out Osears, you certainly would receive one for your acting abilities in the skit that was the hit of the PR Institute recently — 'PR Man on a Hot Tin Roof.' As you know, it went over with a bang and a lot of folks said it should have been presented before the entire Institute audience.

"Thanks to the efforts and contributions of you and our other participants, the Institute was a huge success, with a record-breaking attendance of over 400 medical society leaders and allied people. We want to express our appreciation to you for playing such a lively part in the meeting."

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NEWS of the STATE



ADAMS

The regular monthly meeting of the Adams County Medical Society, preceded by a dinner, was held at the Lincoln Douglas Hotel, Monday evening, Sept. 9. The scientific program was conducted by members of the professional staff of the Adams County Mental Health Center. Dr. Manfred Kydan, psychiatrist, and Mr. Nicholas Bahn, psychiatric social worker of the Center, told how the Center operates. He described clinical patients to illustrate the organization, procedures and goals of the Center. Some 270 patients have been examined and treated since the Center opened; physician referrals have comprised the largest group of referred patients to the Center. Many questions were asked, and it was the opinion of those in attendance that the Center was filling a definite need in the community.

At the business session, the matter of Asiatic flu was discussed. Dr. Alfred Ash, President of the society, was authorized to appoint a special committee to make recommendations in regard to the disease. Drs. Harold Swanberg, E. L. Sederlin, Walter M. Whitaker, and Ernst A. Griep were appointed on this committee. Dr. Manfred Kydan was elected to membership in the society, and applications for membership were read from Dr. E. L. Sederlin, Dr. John P. Wood, Dr. Ralph F. Davis and Dr. William S. White.

Members of the society stood in silent meditation to honor the memory of Dr. Paul M. Brenner of Quincy and Dr. Julian Krakowski of Camp Point, who had died since the previous society meeting.

The next session of the society will be a joint dinner meeting with the Adams County Bar Association, Monday evening, October 7, at the Lincoln Douglas Hotel.

COOK

Hospital News.—Illinois Masonic Hospital recently received a check for $25,000 for care given Ralph Jansen, owner of the Ivanhoe Restaurant who died a year ago. It will be used to buy the Ralph Jansen cobalt bomb deep therapy unit, which will be placed in the hospital's new addition now being constructed.

1956 Tuberculosis Rate High.—Chicago's tuberculosis death rate in 1957 was almost double the national average, Dr. Warren Furey, president of the Tuberculosis Institute of Chicago, recently announced. Dr. Furey released statistics which also showed that new cases reported in the city were two and a half times the national rate. Dr. Furey said there were 439 deaths in Chicago last year from tuberculosis; newly discovered cases totaled 5,644, newspapers reported.

New Clinic Program for Teaching at Northwestern.—A new clinic program has been launched at Northwestern University Medical School, which is designed to develop in its senior medical students a better understanding of the doctor-patient relationship. The program is called the comprehensive medical care clinic. Dr. Edward S. Petersen, director of clinics, describing it as the first full-scale one of its type in the Chicago area. Four senior students are assigned to the clinic. Spending two afternoons a week for twelve weeks in the clinic, each student treats only three patients. But he sees them

often, the report stated, which is the most significant difference between the new clinic and the other clinics Northwestern has been operating in its Montgomery Ward Memorial Building.

Dedicate Garden for the Blind.—On July 21 ceremonies were held to dedicate the garden for the blind, which adjoins the Chicago Lighthouse for the Blind, 1850 Roosevelt Road. The garden is made up of shrubs and plants unique for their special scents. Braille markers provide identification of each plant. The garden will be used as an integral part of the recreation program of the Lighthouse for the Blind. More picnic tables and outdoor barbecue carts will be added as soon as funds are available through the efforts of the women's board of the Chicago Horticultural Society, which was responsible for the idea and development of the garden. Cooperating organizations include the Illinois Road Builders' Association, which cleared the debris from the one and one-half acre plot of land, and the Illinois Nurserymen's Association, which gave trees, shrubs and flowers.

Two Agencies Join in Appeal for Funds.—For the first time, the Community Fund and the Red Cross have combined in a joint appeal for funds, which opened October 1. The two organizations merged their campaign efforts to raise more money to meet urgent and increasing welfare needs; to reduce the amount of volunteer manpower required to raise funds for the two organizations, and to increase the efficiency, economy and effectiveness of fund-raising. According to an announcement, more money is needed than ever before, with a minimum need of 14 million dollars to help support the Community Fund's 162 local welfare services and the Chicago chapter of the American Red Cross.

New Blood Test System.—A new microlaboratory has been opened at Chicago Wesley Memorial Hospital which will permit elaborate diagnostic tests to be made on a single drop of blood, newspapers reported August 15. The facility is expected to speed the health examinations of infants and save the lives of many new born babies on whom such tests are frequently difficult or dangerous to make by conventional methods, it was stated. Some of the tests can be run on as little as one-tenth of a drop of blood. This will prove especially advantageous for babies during the first day of life, it was reported. It will also spare other young children whose veins may be hard to reach or who cannot spare larger amounts of blood needed for standard tests. Dr. Edward J. Fitzsimons, a bio-chemist and director of the hospital's chemistry laboratories, will supervise the new micro installation. Little Company of Mary and Children's Memorial hospitals are among other Chicago area hospitals which also have microlaboratory facilities, all based on techniques which Dr. Samuel Natelson of Rockford helped pioneer many years ago, it was stated.

Promoting Better Care for the Newborn.—A survey was recently made by a committee of the Chicago Pediatric Society with the idea of creating a better understanding between the hospitals of the Chicago Metropolitan area, pediatricians, hospital staffs, administrators, thus promoting better care for the newborn infant. The results of the survey have been classified into a list showing the names of the hospitals, addresses, pediatricians in charge and whether or not visiting privileges are extended and the limit of care permitted. This list may be obtained from Dr. Raymond F. Grissom, Secretary of the Chicago Pediatric Society, 715 Lake Street, Oak Park, Ill. Members of the committee who made the survey are Drs. H. N. Sanford, A. S. Traisman, A. L. Newcomb, M. P. Borovsky, and E. T. McEnergy, chairman.

Specialty Society Election.—Dr. Norman J. Ehrlich was recently installed as president of the Chicago Society of Allergy. Dr. Harold C. Wagner was named president-elect and Dr. Israel A. Fond, secretary-treasurer. All are of Chicago.

Personal.—Drs. James H. Hutton and E. D. Huntington recently won rounds in Class A and B, respectively, August 18, at the Olympic Fields Golf Club. Dr. Hutton scored an 89 and Dr. Huntington, 87.—Dr. M. Edward Davis, chief of service of Chicago Lying-In Hospital, was named president-elect of the American Association for Maternal and Infant Health, newly adopted name for the American Committee for Maternal Welfare. Dr. Deane M. Farley, Berwyn, was named first assistant secretary.—Dr. Max Chorek was recently awarded the honor of commander of the Legion of Honor by the French government.—Dr. Murrey K. Rosenberg has been appointed clinical assistant in anesthesiology in Chicago Medical School.—Dr. Robert P. Gilbert, assistant professor of medicine, Northwestern University Medical School, has been named director of teaching and research at Evanston Hospital. This is a newly created position. Under his direction, the hospital will expand its research program which has made a number of important contributions to medicine. These include a whooping cough vaccine, developed by Dr. Louis W. Sauer, and an immunizing anti-toxin for the prevention of scarlet fever,

achieved by Drs. George and Gladys Dick, a husband and wife medical team, the Chicago Tribune reported.—Dr. Aldo A. Luisada, director, division of cardiology, Chicago Medical School, gave twenty-two lectures in the countries of Peru, Chile, Argentina, Uruguay and Brazil. The tour lasted from August 15 through September 25.

LAKE

Personal.—Donalee L. Tabern, Lake Bluff, head of the radio-pharmaceutical department at Abbot Laboratories, North Chicago, has been elected president of the Central Society for Nuclear Medicine. The society is a professional group of physicians, physicists and chemists from throughout the midwest who are active participants in nuclear medicine. The organization is a chapter of the National Society of Nuclear Medicine, of which Dr. Tabern is a charter member, newspapers reported.

WARREN

Dr. Firth First Physician to Hold Legion Post.—Dr. John O. Firth, Monmouth, president of the Warren County Medical Society, was elected grand chef de gare of the Illinois American Legion during its recent convention in Chicago. Dr. Firth has been the department of Illinois surgeon and medical adviser since 1955. He is co-chairman of the Committee on Nursing of the Illinois State Medical Society and the first doctor of medicine to hold the office of grand chef de gare. Dr. Firth is also coroner of Warren County.

WINNEBAGO

Changes of Address.—The Bulletin of the Winnebago County Medical Society reports the following changes of address: Dr. T. A. Baumann from 5420 North Second Street to 520 Gregory Street; Dr. L. C. Brooks from 526 West State Street to Talcott Building; Dr. W. D. Jones from 1632 Broadway to 501 Seventh Street; Dr. Chester T. Roe from 2300 North Rockton Avenue to 115 Seventh Street; Dr. David Welsh from Talcott Building to 2300 North Rockton Avenue. All are in Rockford.

Health of the School Child.—"The Importance of the School Health Examination in the Health of the School Age Child" will be the theme of an all day conference in Rockford, November 6. A. Rowland Tood, executive secretary of the Community Welfare Council, will open the session with an address of welcome. The subjects "What is the school health examination" and "How is the examination given" will be discussed by physicians. "Findings from the examinations (1956-1957) will be discussed by a nurse from the Board of Education, while "Follow-up procedures on examination" will be covered by Mrs. Alma Hall, also of the board of education, and a local pediatrician. A two hour session in the afternoon will be devoted to "How do community health personnel work together on the school health examination". John M. Catlin, executive director of the Winnebago County Tuberculosis Association, will be moderator of the panel which will be composed of a physician, school principal, voluntary health agency staff member and a parent. Representatives from other health and welfare agencies will participate in the discussion period.

GENERAL

New Advisory Board to Division of Alcoholism.—Two physicians and five laymen have been named to serve as an advisory board to the newly created division of alcoholism in the Illinois Department of Welfare. The appointees, made by Governor Stratton, are Dr. Clarence Boyd of Marion; State Sen. Marvin Burt (R., Freeport); Clem Lane, city editor of the Chicago Daily News; Wesley K. Hunt, a Chicago printing executive; Dr. John Madden, professor of psychiatry, Stritch School of Medicine of Loyola University; Paul B. Musgrove, Peoria, industrial relations manager of the Hiram Walker distillery, and John J. Oughton Jr., head of the Keeley Institute, Dwight. The new division of alcoholism was created by the 70th General Assembly to administer the state program for care and rehabilitation of alcoholics.

Symposium on Radioisotopes.—All physicians are invited to attend a symposium on radioisotopes at the Brooks Memorial Union at Marquette University, Milwaukee, presented by the Milwaukee Academy of Medicine, December 7. The faculty will be: William Bloom, M.D., professor of anatomy, University of Chicago, "Basic Cellular and Histologic Changes Produced by Radiation Energy;" Austin M. Brues, M.D., director, Biology Division, Argonne National Laboratory, moderator; Edward A. Doisy, Jr., M.D., associate professor of internal medicine, St. Louis University School of Medicine, "Radioisotope Chemistry"; Titus C. Evans, Ph.D., professor of radiation research, State University of Iowa College of Medicine, Iowa City, "Basic Nuclear Physics and Instruments"; E. M. K. Geiling, M.D., Ph.D., professor of pharmacology, University of Chicago, "Radioisotope Pharmacology."; Harvey M. Pratt, Ph.D., senior physiologist, Argonne National Laboratory, "Basic Radiation Biology", and Joseph F. Ross, M.D., professor of medicine and associate dean, University of California School of Medicine, "Radioisotope Physiology". There

is no registration fee for the symposium. Reservations may be made by writing to the Milwaukee Academy of Medicine, 561 North Fifteenth Street, Milwaukee 3, Wis. Final programs may be had on request.

Lectures Arranged by the Illinois State Medical Society:—

George H. Klumpner, Oak Park, Unity Nurses' Club, Carleton Hotel in Oak Park, October 22, on "Psychosomatic Medicine."

E. Clinton Texter, Jr., assistant professor of medicine, Northwestern University Medical School, addressed the Bureau County Medical Society in Princeton, September 10, on "Newer Concepts of Peptic Ulcer."

Jack W. Fischer, associate clinical professor of medicine, University of Illinois College of Medicine, addressed LaSalle County Medical Society in Ottawa, September 12, on "Treatment of Coronary Thrombosis Including Anticoagulant Therapy."

James P. Ahstrom, Jr., member of the staff of Shriners Hospital for Crippled Children, addressed the Champaign County Medical Society in Champaign, September 12, on "Fractures in Children."

Laurence H. Rubenstein, associate in surgery, Chicago Medical School, addressed the Lee and Whiteside County Medical Societies in Dixon, September 19, on "Surgical Approaches to the Heart."

Hamper Kelikian, associate professor of orthopedic surgery, Northwestern University Medical School, addressed the Stephenson County Medical Society in Freeport, September 19, on "Surgical Treatment of Arthritis."

H. Close Hesseltine, professor of obstetrics and gynecology, University of Chicago School of Medicine, led a round table discussion on obstetrics and gynecology at a meeting of the Illinois Chapter of the American College of Surgeons at the Winnebago County Medical Society in Rockton, September 21.

Hilger Perry Jenkins, clinical associate professor of surgery, University of Illinois College of Medicine, addressed the Macoupin and Montgomery County Medical Societies in Carlinville, September 24, on "Film Composite of Surgical Problems in General Practice."

Edward A. Piszczek, Executive Director, Suburban Cook County Tuberculosis Sanitarium District, Englewood Branch of the Chicago Medical Society at the Englewood Hospital Nurses' Home, October 1, on Influenza Immunization including "Asian Flu."

J. Henry Heinen, Jr., clinical instructor in orthopedic surgery, University of Illinois College of Medicine, Bureau County Medical Society in Spring Valley, October 8, on "Fractures of the Lower Extremities."

John R. Wolff, clinical assistant professor of obstetrics and gynecology, University of Illinois College of Medicine, Champaign County Medical Society in Champaign, October 10, on "Office Gynecology."

Walter C. Bornemeier and Frederick W. Slobe, members of the Committee on Medical Economics of the Illinois State Medical Society, Stephenson County Medical Society in Freeport, October 17, on "Pro and Con of Social Security."

Angelo P. Creticos, member of staff of Henrotin Hospital, Stock Yards Branch of the Chicago Medical Society, in Evangelical Hospital, October 18, on "Diagnosis and Management of Coronary Artery Disease."

Joseph T. O'Neill, Ottawa, Councilor of the Second District of the Illinois State Medical Society, Marseilles School Parent Teacher Association in Marseilles, November 7, on "Your Child's Health."

John T. Grayhack, assistant professor of urology, Director of Kretschmer Memorial Laboratory, Northwestern University Medical School, Champaign County Medical Society in Champaign, November 14, on "Common Urological Problems."

H. Close Hesseltine, professor of obstetrics and gynecology, University of Chicago School of Medicine, Stock Yards Branch of the Chicago Medical Society at Evangelical Hospital, November 15, on "Conduct of Prolonged Labor: Use and Abuse of Pituitary Extract."

Eugene F. Diamond, clinical instructor in pediatrics, Stritch School of Medicine of Loyola University, Woodfield Woman's Club in Palmer Park, Chicago, November 18, on "Understanding the Adolescent."

DEATHS

Ralph C. Aiken*, Blue Island, who graduated at Northwestern University Medical School in 1921, died August 1, aged 66. He was a member of the staff of St. Francis Hospital in Blue Island and Ingalls Memorial Hospital in Harvey.

August Allan Bauer*, Kankakee, who graduated at the Chicago Medical School in 1928, died in a hospital in Los Angeles, June 23, aged 60, of cerebral hemorrhage. He was a member of the Radiological Society of North America and the American College of Radiology.

Albert Eugene Dennison*, Oak Park, who graduated at Rush Medical College in 1895, died June 7, aged 87, of adenocarcinoma of the colon with metastasis to the liver. He

*Indicates member of the Illinois State Medical Society.

was a member of the staff of the West Suburban Hospital.

William J. Dieckmann*, Chicago, who graduated at Washington University School of Medicine, St. Louis, in 1922, died August 15, aged 59. He was Mary Campau Ryerson professor of obstetrics and gynecology at Lying-in Hospital of the University of Chicago. From October 1942 until January 31, 1954, he was chairman of the department of obstetrics and gynecology of the University of Chicago School of Medicine and chief of staff of the Lying-in Hospital of the University.

Kinsey O. English*, Chicago, who graduated at Rush Medical College in 1930, died August 6, aged 62. He was a staff member of the West Suburban Hospital in Oak Park.

Alfred Edward Everett*, Granite City, who graduated at St. Louis College of Physicians and Surgeons in 1902, died June 12, aged 83. He was past-president of the Madison County Medical Society.

Harvey Farrington, Glenview, who graduated at the Hahnemann Medical College and Hospital of Philadelphia in 1896, died June 9, aged 84.

Lorin Lycurgus Fowler*, Marion, who graduated at the St. Louis College of Physicians and Surgeons in 1907, died June 1, aged 80, of coronary occlusion. He was a member of the staffs of the Anna State Hospital and Marion Memorial Hospital.

Henry W. Gentles*, retired, Chicago, who graduated at the University of St. Andrews Conjoint Medical School, St. Andrews and Dundee, Scotland, in 1889, died August 23, aged 90. He was former director of first aid for the Chicago Chapter of the American Red Cross.

Charles H. Hair, Chicago, who graduated at Jenner Medical College in 1910, died March 7, aged 80.

Henry Francis Hall, Chicago, who graduated at Meharry Medical College, Nashville, in 1909, died in the Manteno State Hospital April 14, aged 80.

William Eugene Hervey*, East St. Louis who graduated at Bennett Medical College, Chicago, in 1911, died June 2, aged 75, of cerebral hemorrhage. He was associated with St. Mary's Hospital and the Christian Welfare Hospital.

Augustus Stout Hunt, retired, Normal, who graduated at the Homeopathic Medical College of Missouri in 1899, died in the Veterans Administration Hospital, Dwight, June 11, aged 85.

Charles Edwin Johnson, Homer, who graduated at Marion-Sims College of Medicine, St. Louis, in 1897, died May 18, aged 84, of arteriosclerotic heart disease.

Frank B. Knudson*, retired, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1899, died September 7, aged 83. He was a staff member emeritus at the Lutheran Deaconess Hospital.

Sarantos C. Loumos, Chicago, who graduated at the National University of Athens School of Medicine, Greece, in 1914, died September 8 as he was riding to a dinner party in his honor. He was formerly a staff physician at Elgin State and Chicago State Hospitals.

Curtman McMahon, retired, Springfield, who graduated at St. Louis College of Physicians and Surgeons in 1907, died May 30, aged 71.

Edmond R. Moras, retired, Libertyville, who graduated at Harvard Medical School in 1888, died August 3, aged 92. He had practiced medicine many years in Highland Park.

Scott T. Petrie, Chicago, who graduated at Harvey Medical College, Chicago, in 1904, died May 13, aged 82, of cancer.

Charles Theodore Root*, Jacksonville, who graduated at the University of Michigan Homeopathic Medical School, Ann Arbor, in 1914, died April 10, aged 74, of myocardial infarct and coronary arteriosclerosis. He was a member of the American Society of Anesthesiologists and the American Trudeau Society.

Anthony Santoro*, River Forest, who graduated at Loyola University School of Medicine in 1930, died August 24, aged 58. He was chief surgeon for the Chicago fire patrol and a member of the executive staff of West Suburban Hospital.

Robert N. Swindle, retired, West Palm Beach, formerly of Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1906, died August 17, aged 73. He was a member emeritus of the Calumet Branch of the Chicago Medical Society and a former member of the staff of Roseland Community Hospital.

Axel F. Werelius*, retired, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1902, died August 8, aged 86. He was one of the founders of South Shore Hospital and former chief of its surgical staff, and a member of the staff of the Illinois Central Hospital.

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*Indicates member of the Illinois State Medical Society.



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WOMAN'S AUXILIARY



An open letter to Dr. and Mrs. Reavley

Thank you for your very nice letter of recent date, sent by Mrs. Reavley, which is as it should be. Our main purpose as doctors' wives should be to assist our busy husbands in every conceivable way. Thus, a word from your wife was appreciated, and I take this opportunity to reply in an open letter to you, who represent more than 11,000 physicians in ILLINOIS.

Our Auxiliary year began successfully with an excellent Advisory Committee, appointed by Doctor H. Close Hesseltine, Chairman of the Council. His fine choice of advisors, headed by our good friend Doctor Walter C. Bornemeier, included Doctors C. Elliott Bell, Decatur; C. Henry Mundt, Chicago; Joseph T. O'Neill, Ottawa; and Harry J. Dooley, Chicago. We are grateful for the services of these gentlemen, who have proved in the past that their interest in the Auxiliary is sincere and deep. Won't you please express our thanks to each of them for their kindness in giving of their time and thoughts. We shall try to repay their devotion by exemplary conduct, and extraordinary service to the Society *per se*.

We would like to thank the Society for giving us the assistance that makes it possible for us to exist. This includes the printing of our stationery, rosters, and handbooks, plus the countless odd jobs of duplicating, mailing, and editing. The courtesy shown us by the Monmouth and Chicago offices is far beyond expectations. We know you will be happy to learn of the cordial relationship that exists between the staff of your Society and the Woman's Auxiliary. We wouldn't be able to accomplish any part of what we have been able to do without your Mrs. Zimmer, Mrs. Rutherford, and Miss Fox. Their articulate and friendly assistance have helped us over the rough spots on innumerable occasions.

Thank you also for the assistance of the gentlemen in the Society's offices: Doctor Harold Camp has been a friend to the Auxiliary since its inception 30 years ago. He has never faltered in his acceptance of our organization and has been kind and generous beyond duty. The tremendous assistance given by the Public Relations staff, which includes Mr. Edward Uzemack and Mr. John Mirt has made all the difference in the success of our operations. Their work is not seen, and therefore must be praised in this manner. Our final thank you is to the man of our auxiliary life. It is with a thorough knowledge of his efforts to activate the Auxiliary and exert aggressiveness from them on legislative fronts, that we bow to Mr. Walter Oblinger. With his help and information we have made strides in our legislative endeavors.

Our program this year will include many bright innovations. We think you would like to learn of some of them. As the result of our newly approved Constitution and By-Laws, dis-

(*Continued on page* 62)

for the first few days of life

VI-PENTA #1

provides K, E, and C, the vitamins needed particularly by prematures and newborns.

for infants and young children

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provides vitamins A, D, C, and E, essential for normal development.

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WOMAN'S AUXILIARY (Continued)

trict meetings will be handled through the respective Counsellors, under the capable direction of the President-Elect, Mrs. Fred C. Endres of Peoria. If the Doctors can see their way clear, I am sure they will assist this worthwhile undertaking. This will result in better organization for Illinois, which now rates at the bottom, nationally.

Our State Legislation Chairman, who is reporting in this column, has challenged each physician's wife in Illinois. Mrs. Norman L. Sheehe will prove to be of tremendous assistanee this year in laying the groundwork for truly effective legislative activity in the years ahead.

Doctor, you know what a critical shortage exists amongst all medical technologists in the entire nation today. Our Recruitment Chairman, Mrs. Charles L. Wunsch is diligently working on behalf of the entire profession, in interesting the youth of Illinois to become aware of the many fine opportunities that await them in our medical world.

You know our efforts will continue always in behalf of the Benevolent Fund. Not because benevolence remains one of our objects in the Constitution but because each member of the Auxiliary is thankful it is her privilege to give rather than to receive.

One last memo, Doctor Reavley: we feel it unnecessary to mention, but our efforts as true PR representatives will be consistent all through the days to come. For the 2,901 members which it is my privilege to represent, may I say, we are proud to be part of the noblest profession in existence. We love every sacrifice we are called upon to make and will try always to uphold the high ideals exemplified by your profession.

Doctor, if the Auxiliary can do anything to be of additional help to the Society, please don't hesitate to let us know. Our job is to do all we can to assist the Illinois State Medical Society in its program for the advancement of medicine and public health. Do keep us in mind. And ask the many doctors, whose wives are not yet acquainted with our good works to join in membership. It is something they will always cherish.

(*Continued on page* 66)

when anxiety and tension "erupts" in the G. I. tract...

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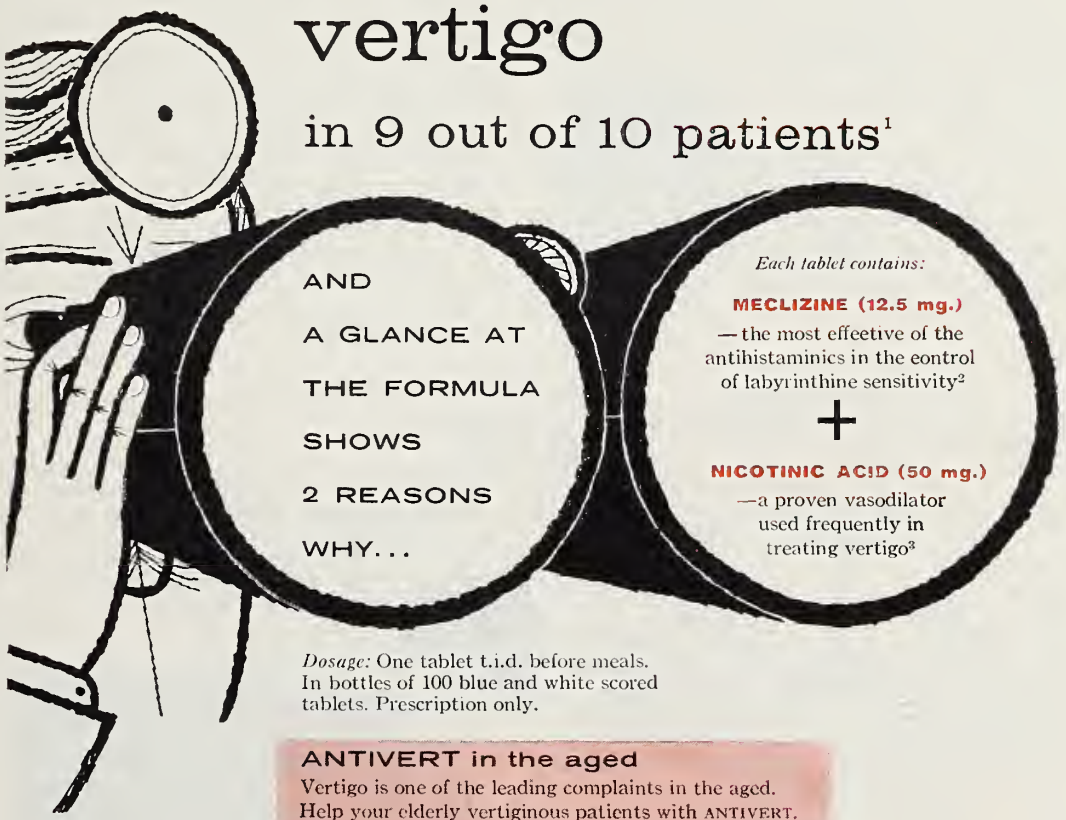
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References: 1. Menger, H.C.: Clin. Med. *4*:313 (March) 1957. 2. Charles, C.M.: Geriatrics *2*:110 (March) 1956. 3. Shuster, B.H.: Med. Clin. of N. Amer. *40*:1787 (Nov.) 1956.

ROERIG New York 17, New York

Give our best to Mrs. Reavley, and tell her we antieipate seeing her at our Fall Conferenee at Roekton.

Sineerely,
Mrs. Nicholas G. Chester,
President,
Woman's Auxiliary
Illinois State Medieal Society

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Wanted . . . your wife!

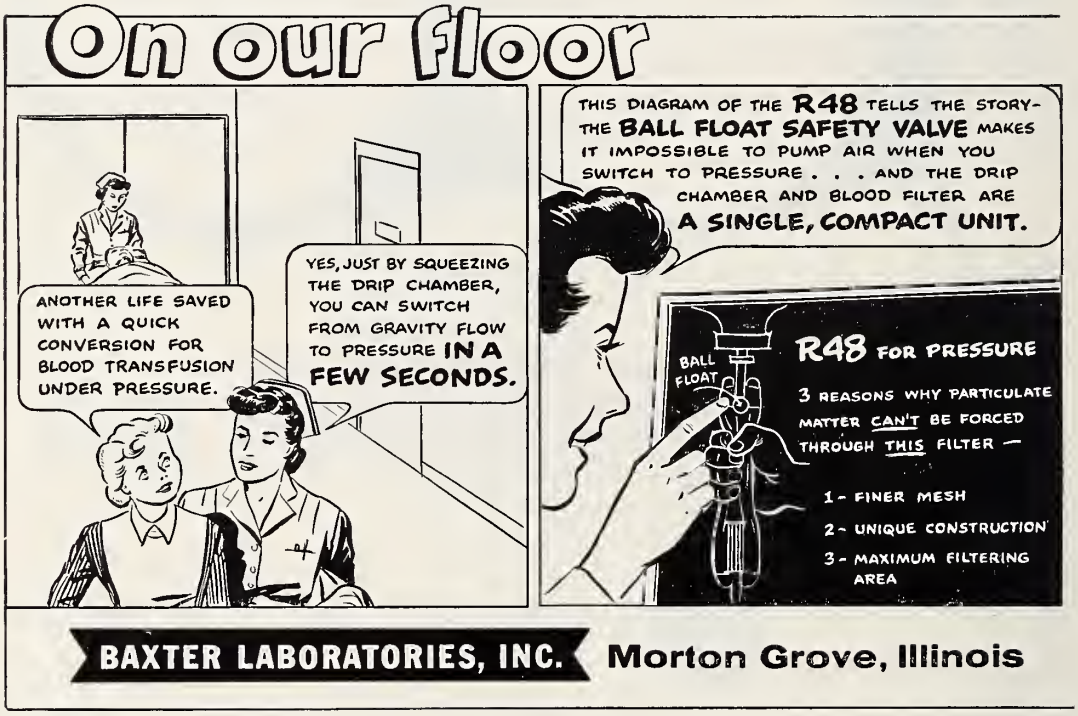
We need your help. We're on a serious mission of finding lost wives this month. Let's explain. They aren't aetually missing — let's just say that their interest is missing from a cause you hold elose to your heart. We refer to the legislation ineorporated in your all important legislative program.

If your wife is a member of the Woman's Auxiliary to the Illinois State Medieal Soeiety but not partieularly interested in the aims sought in your legislative program (beeause she isn't familiar with it), or if she is one not yet convineed that her assoeiation with us in membership would give her an opportunity to aid in promoting that program, please find her for us and tell her she is needed and wanted. We must aeeomplish our goal and to do this, we must be strong in numbers.

As members of your Auxiliary, we know the true meaning of being an "auxiliary" and we want to be just that. There are certain things we can do to assist you and one is legislation efforts. We have no legislative program of our own. Our interest is your interest. And who eould better help you in this work than we who know and understand and believe in you.

Our legislative program is guided and directed by Mr. Walter L. Oblinger, Associate Counsel, Illinois State Medical Soeiety. No aetion is ever taken by our membership without his knowledge and sanction. In order to assist him and be able to do our best we shall try to foresee our legislative results for 1958. Toward that end, your Auxiliary has inaugurated a four C program for the coming year!

1. CONCENTRATE — To study all legislative matters in your program in order to become better informed regarding what



we ask our law makers to support. But first, we shall learn who our individual legislators are and the important rules to follow.

2. CO-OPERATE — Knowing and understanding your legislative aims, we shall stand by for the call to act.

3. CONTACT — When the call comes, we shall contact our legislators immediately for time is of the essence. We shall send them our thanks, too, if it has been deserved.

4. COLLECT — We shall save our replies and forward them to Mr. Oblinger. They will be valuable, when tabulated, in determining our strength or weakness and guide us accordingly.

Can you foresee successful results with our four-C program? With the gracious and strong leadership of our President, Mrs. Nicholas G. Chester, plus the interest and help of your wife, we cannot fail you.

Marie L. Sheehe
Marie L. Sheehe (Mrs. Norman L.)
Chairman of Legislation.

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Fig. 231



Quickly hung from any door. Made of white double coutil, fleece-lined. Buckle adjustments permit fitting to any head size. Halter comes complete with pulley system, door-top support, spreader bar, weight bag.

Indications for use: Successful treatment for pain resulting from complications in the area of the cervical spine; low back disorders, lumbosacral strain, herniated cervical disks, osteo-arthritis of cervical spine, muscle spasm of the neck, fibrotic conditions, some cases of sciatica, and many other conditions requiring steady traction.

HORIZONTAL TRACTION ASSEMBLY (Fig. 321-A) with pelvic belt $17.50. Measurements required: circumference 3 inches below iliac crests.

ADJUSTABLE LUMBO-SACRAL SUPPORT our price **$6.50**



Fig. 194

5″ to 7″ Front
6″ to 10″ Back

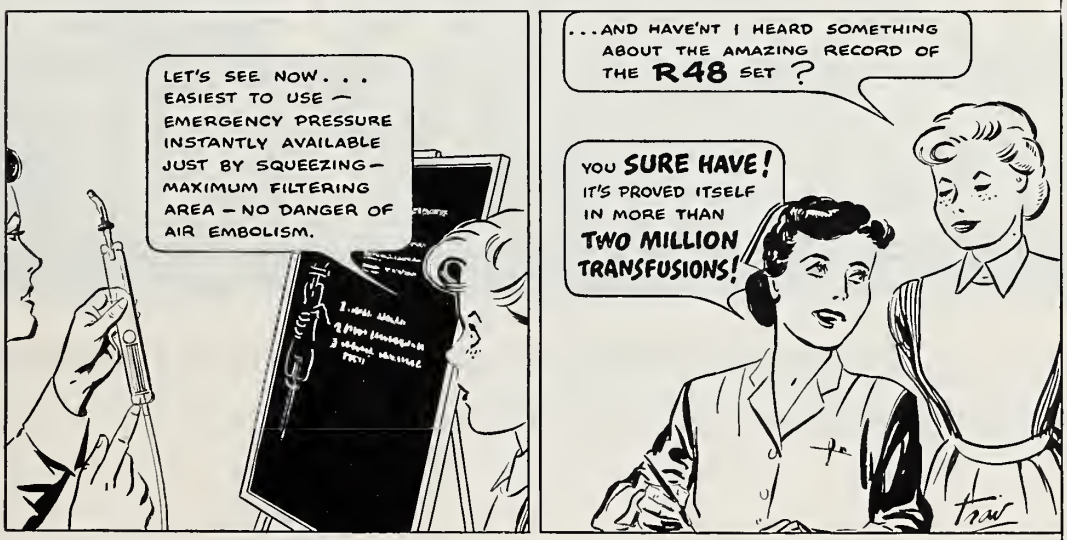
Made of herring bone weave 2 ply coutil, reinforced in back, sides and front with stays. Supplied with removable sacral pad and perineal straps.

Take measurements around the hips three inches below the iliac crest.

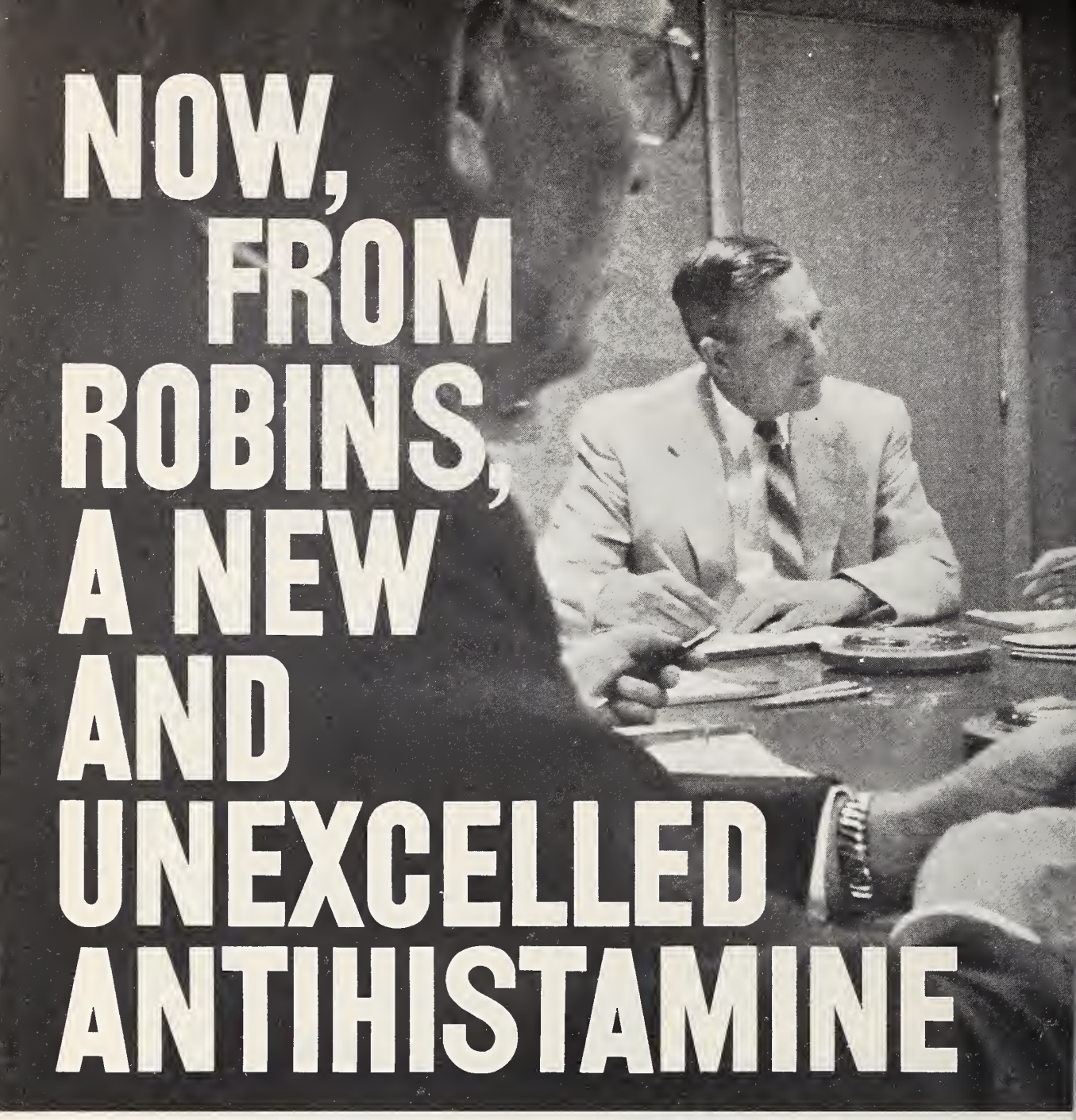
(Fig 101) Sacroiliac Belt $4.50

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Diagnosis	No. of Patients	Response				Side Effects
		Excellent	Good	Fair	Negative	
Allergic rhinitis and vasomotor rhinitis	30	14	9	5	2	Slight Drowsiness (3)
Urticaria and angioneurotic edema	3	1	1	1		Dizzy (1)
Allergic dermatitis	2		1	1		Slight Drowsiness (2)
Bronchial asthma	1		1			
Pruritus	1		1			
Total	37	15	13	7	2	Drowsiness (5) Dizzy (1) 16.2%

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or prophylaxis in
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Sulfacetamide . . .	100 mg.

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1. Kerley, L., and Headlee, C. P.: J. Am. Pharm. A. (Scient. Ed.) 45:82, 1956. 2. Lehr, D.: Special Exhibit, Mod. Med. 23:111, No. 2, 1955. 3. Editorial, J.A.M.A. 160:210, 1956. 4. Bastedo, W. A.: Materia Medica, Pharmacology, Therapeutics and Prescription Writing, ed. 4, Philadelphia, W. B. Saunders Company, 1937, pp. 514, 101

THE E. L. PATCH COMPANY
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BOOK REVIEWS



OF WATER, SALT AND LIFE. Lakeside Laboratories, Inc. Milwaukee, Wisconsin. 72 pages, 31 plates, $7.50.

This book is an atlas of fluid and electrolyte balance in health and disease. It "incorporates the abundant new knowledge concerning an increasingly significant area of clinical medicine." The work consists of four sections: "Physiological Considerations," "Pharmocology of Diuresis and Anti-Diuresis," Disorders of Fluid and Electrolyte Balance," and "Fluid and Electrolyte Replacement Therapy."

The illustrations are in six colors, and graphically portray some of the complex questions in the text. In fact, without these diagrammatic devices, the work would be difficult to understand.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will glady furnish same promptly.

CURRENT SURGICAL MANAGEMENT — A Book of Alternative Viewpoints on Controversial Surgical Problems. Editors: John H. Mulholland, M.D., Editor-in-Chief, New York University College of Medicine; Edwin H. Ellison, M.D., Ohio State University College of Medicine; Stanley R. Friesen, M.D., University of Kansas Medical Center. With contributions by 76 American authorities. 494 pages, illustrated. W. B. Saunders Company, Philadelphia and London. $10.00.

IT PAYS TO BE HEALTHY by Robert Collier Page, M.D., F.A.C.P., Prentice-Hall, Inc., Englewood Cliffs, New Jersey. $4.95.

PSYCHOPATHIC PERSONALITIES By Harold Palmer, M.D. Philosophical Library, New York. $4.75.

MEDICAL WRITING — The Technic and the Art. By Morris Fishbein, M.D., formerly Editor, The Journal of the American Medical Association; Contributing Editor, Postgraduate Medicine; Editor, Excerpta Medica, Amsterdam. Third Edition. The Blakiston Division, McGraw-Hill Book Company, Inc., New York, Toronto and London. $7.00.

MODERN PERINATAL CARE. By Leslie V. Dill, M.D., F.A.C.S., Diplomate of the American Board of Obstetrics and Gynecology; Associate Clinical Professor, Obstetrics and Gynecology, Georgetown University School of Medicine. Appleton-Century-Crofts, Inc., New York. $6.50.

A BOOK OF CONTEMPLATION by Dagobert D. Runes. Philosophical Library, New York. $3.00.

FROM STERILITY TO FERTILITY — A Guide to the Causes and Cure of Childlessness. By Elliot E. Philipp, M.A., M.B., B. Chir. F.R.C.S., M.R.C.O.G., Philosophical Library, New York, New York.

CLINICAL TOXICOLOGY OF COMMERCIAL PRODUCTS — Acute Poisoning (Home and Farm). By Marion N. Gleason, Research Assistant in Pharmacology, School of Medicine and Dentistry, The University of Rochester, Rochester, N. Y.; Robert E. Gosselin, M.D., Ph.D., Professor of Pharmacology, Dartmouth Medical School, Hanover, N. H.; Harold C. Hodge, Ph.D., D.Sc., Professor of Pharmacology and Toxicology, School of Medicine and Dentistry, The University of Rochester, Rochester, N. Y. The Williams & Wilkins Company, Baltimore.

IN PATIENTS WITH "ANXIETY—TENSION—FATIGUE"



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In patients with anxiety-tension-fatigue, electromyographic studies have shown that their tense skeletal muscles cannot readily stop contracting on command. This is considered a major cause of their fatigue. After a course of 'Miltown' therapy the muscles relax at will and can therefore more readily recover from fatigue.

This simultaneous relief of mental and muscular tension is a unique property of 'Miltown'.

Investigators[1,2] have concluded that in patients with anxiety-tension-fatigue 'Miltown' therapy is of great value in improving the individual's capacity to work efficiently.

1. Dickel, H. A., Wood, J. A. and Dixon, H. H.: Electromyographic studies on meprobamate and the working, anxious patient. Ann. New York Acad. Sc. **67**:780, May 9, 1957.

2. Dickel, H. A., Dixon, H. H., Wood, J. A. and Shanklin, J. G.: Electromyographic studies on patients treated with meprobamate. West. J. Surg. **64**:197, April 1956.

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Mutations and new diseases

Can mutations change the habit and virulence of bacteria sufficiently to cause a new disease to modify an old one? I am not sure. To produce mutations which differ from their parents in colonial form or biochemical behavior is among one of the favorite parlor tricks of bacteriologists. Since some or all of these habits depend upon the intrinsic enzymes of the bacterial cell, and since the power to invade the tissue also seems to depend upon enzymes, it is a fair guess that mutations can occur. Besides, if they cannot, many of the most favored theories of the epidemiologists are lost without trace. I admit that experimental evidence for changes in virulence in bacteria is a bit shaky but until you have tackled the problem you have no idea of the practical difficulties. On the whole I would say that the evidence in favor of the theory would convince a bacteriologist but not a theologian. I see no reason why mutations toward benignity should not happen. This may explain why scarletina no longer decimates the young. It might modify our self-esteem when we talk of the conquest of diphtheria. It is conceivable that mutation in the parasite might abolish a disease altogether. Where, if anywhere, are the English sweats? Perhaps they masquerade under the name of infection with adenovirus. The changing pattern of disease is not all our doing, nor is the chemical change all in one direction. Accurate observation and intelligent imagination put rickettsialpox in the textbooks quite recently. Is this a disease not recognized before? Or have rickettsie only recently learned to spread from mouse to man? Or is it really a new disease, the first venture in parasitism by an organism which previously had kept itself to itself? *The Widdicombe File. Lancet. Aug.* 10, 1957.

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Endometriosis

A few cases have been reported in which it was believed that endometriosis has been transformed into actual cancer. If, indeed, endometriosis is a malignant disease, then it must be regarded as being of extremely low grade malignancy. *Practitioners' Conference, Endometriosis. New York Med. June* 20, 1957.



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Menstrual epilepsy

The occurrence of convulsive seizures in relation with the menstrual period is not rare, and when such attacks are limited strictly to this phase the question of positive endocrine causation is raised. When the attacks are typically epileptiform, being associated with loss of consciousness, convulsive movements, frothing of the mouth, and biting of the tongue, there is rarely any doubt that they represent genuine epilepsy. There may be a history of definite aura preceding the attacks, and they often are followed by a phase of mental confusion. In other cases, attacks of petit mal are noted, and these may present a more difficult problem. Our observation has been that epilepsy may show a striking predilection, in its early stages, for the menstrual periods although, as the disease progresses, attacks occur intermenstrually as well. *Textbook of Gynecology, by Drs. Emil and Edmund R. Novak.*

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Meat needs of the aged

Findings of a five year study indicate that healthy aged women, with a few exceptions, can maintain a good nutritional status on a daily minimum intake of approximately 54 gm. of protein, of which 39 per cent is derived from meat, in a self-selected diet of about 1,560 calories. However, during convalescence from any cause, 39 elderly subjects were found to consume, on a self-selection basis, 64 to 98 gm. of protein daily in diets providing 1,935 to 3,484 calories. Meat proteins constituted an average of 27 per cent of the total dietary proteins. In spite of this relatively high food consumption, about 50 per cent of the convalescent patients were in negative nitrogen balance. The daily addition of 600 to 900 mg. of lysine to the diet was found to significantly improve the N-balance of about 60 per cent of these patients. This improvement was noted in those who were initially negative, low positive, and apparently normal N-balances. Our findings indicate that small additions of lysine to the diet of elderly adults under nutritional stress greatly enhance the biologic value of diets, especially those in meat proteins. *A. A. Albanese, Ph.D. et al. Protein and Amino Acid Needs of the Aged. Geriatrics. August* 1957.

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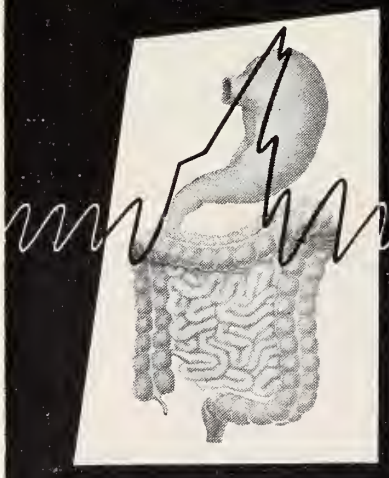
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GI hemorrhage

Fifty patients (with acute upper gastrointestinal hemorrhage) were handled solely by medical means. Two patients died as a direct result of hemorrhage, one of these due to esophageal varices, the other being moribund on admission. Two patients subsequently died of causes unrelated to their gastrointestinal disease; 20 developed subsequent symptoms or X-ray evidence of ulcer activity, and nine of these had one or more subsequent hemorrhages controlled by medical means. Twenty became asymptomatic, with no X-ray evidence of ulcer activity on follow-up exam; six were lost to follow-up.

Twenty-six cases had combined medical and surgical management. Three required emergency surgery; two of these underwent subtotal gastric resection, one dying on the second postoperative day; the other surviving; and the third surviving gastroenterostomy and cauterization of the ulcer. Elective surgery employed in the remaining 23 included 21 subtotal gastric resections with no mortality. Two survived dehiscence of the duodenal stump and two developed postgastrectomy syndrome. Gastroenterostomy was done in two cases and one of these continued to have ulcer symptoms postoperatively. The other later developed symptoms suggestive of a recurrent tumor with surface erosion that was successfully resected. Of the 76 cases, three died as a direct result of their hemorrhages, a gross mortality of 3.9 per cent. One of these patients treated medically was moribund on admission and the other had massive hemorrhage from esophageal varices. The other died following emergency resection for massive hemorrhage and conceivably could have been saved by early resection; however, the indications for surgery were not present until too late. The small number of deaths in the entire series makes statistical evaluation insignificant. The end results of our medically treated cases compare favorably with those in the literature, and indicate such treatment to be preferable to immediate or even blind gastric resection in all cases of massive upper gastrointestinal hemorrhage. *David F. Kapp, M.D. and John E. Jeffrey, M.D. Immediate Management of Acute Upper Gastrointestinal Hemorrhage. Guthrie Clin. Bull. April* 1957.

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Medical practices in India

Social custom, religion, and superstition also affect the practice of medicine. The government of India has outlawed the caste system but it still exists in the villages. People of one caste will not eat food prepared and served by one belonging to another caste. Most patients entering the hospital bring their own relatives, who will cook and serve them while they are hospitalized. I recall one patient who walked barefoot for three days and nights to reach the hospital. Rather than accept food from the mission during convalescence from his cataract operation, he preferred to walk back home. He later returned with his relatives who would feed him. There was another patient who suddenly left the hospital on the fourth day after a cataract extraction without any explanation. The other patients told us he had not eaten any food because it was not prepared by someone from his caste. Finally, when he could no longer stand starvation, he returned home. *Richard A. Ellis, M.D. The Practice of Medicine in India. Pennsylvania M.J. July* 1957.

Absenteeism from colds

Loosli's recent studies of the occurrence of common colds in industry showed that a comparatively small number of industrial workers contributed most of the absenteeism attributable to common colds. It is difficult for a virologist to conceive of viruses behaving in so illogical a manner. I might add, as the father of eight children, six of whom are in school, that I cannot escape the feeling that there is a definite association of "colds" with Monday mornings. It is difficult to think of even "virus X" as causing these Monday morning episodes. Perhaps there is a "Monday morning virus." However, I think the victorians had a better word for it. The expression, "she is indisposed" occurs time and again in victorian literature. It is possible that occasionally this truly represented a viral indisposition but I wonder whether such a virus could be grown even with modern tissue cultures or that present or future miracle drugs could cure it. *Robert J. Huebner, M. D. Implications of Recent Viral Studies. Pub. Health Rep. May* 1957.

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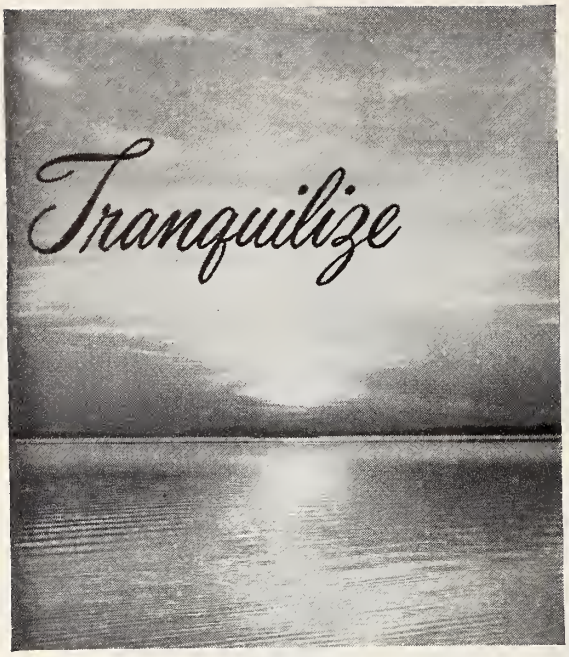
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The Pan American Association of Opthalmology, an 18-year-old organization with some 2,000 members representing all the countries of the western hemisphere, will hold its second cruise congress, February 1-14, on board the S. S. Queen of Bermuda. The itinerary includes a day each in San Juan, Puerto Rico; Ciudad Trujillo, Dominican Republic; Kingston, Jamaica; Port-au-Prince, Haiti, and Nassau, Bahama Islands.

Dr. James H. Allen, New Orleans, is chairman of the program committee, which is arranging symposia, papers, motion pictures, seminars and exhibits stressing subjects of current interest in diseases of the eye. Meetings will be held on shipboard and also in port cities with local societies of ophthalmologists. There will be opportunities to visit hospitals and to meet the staffs of medical schools in the islands.

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The recovery room

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Macular ophthalmology

One of the delightful features of macular ophthalmology is that we so frequently hit upon things we have never seen before. Thus clinicians with over 20 years of hard experience to their credit can be flummoxed by some rare lesion which the novice diagnoses without hesitation because he happened to be shown something similar last week. Figures setting out the average frequency of this and that disease necessarily fail to convey the haphazard disparity between one man's experience and that of another. *James H. Doggart, M. D. Macular Lesions in Everyday Practice. Lancet. Aug.* 3, 1957.

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Certain aspects of suicide

Like Sampson in the temple, the suicide may believe unconsciously that by an act of self-destruction, he is encompassing the destruction of myriads of others who, by ignoring the irrational expectations which he has placed on them to be his substitute parents, have earned his hatred and his anger. The suicide, when he dies, kills not one person but many. He commits not only suicide but vicarious matricide, patricide, sororicide, fratricide, and even genocide. But perhaps the saddest thought of all is to see the suicide as he really is — a forlorn, beaten, and deprived person who has peopled his emptiness with malefactors and villains of his own making. His small, ingrown self becomes an empty cosmos peopled with his tormentors and detractors. In an immense moment of fantastic grandiosity he lays them and all the world to ruin. But instead of leaving the world as he fantasies it, desolated and sere, stricken and laid waste by the magnitude of his act, he gains only a personal surcease from pain and a small footnote on the inside pages of a newspaper. He goes out — not with a bang but with a whimper, a dupe to the irrationality within himself. *C. W. Wahl, M.D. Suicide as a Magical Act. Bull. Menninger Clin. May,* 1957.

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The American Cancer Society advocates a "pelvic examination for the most complete protection — repeated at six month intervals for those over 35 years of age." There are 218,061 physicians in the United States: of these, 11,794 are limiting their practice partly or entirely to obstetrics and/or gynecology, while many are interested in the other specialties. There are 36,194,000 women over the age of 35 years in the United States, so it is obvious that the routine periodic pelvic examination of women for the early recognition of carcinoma can be accomplished only if these examinations are done by and large in the family physician's office. *J. Vernon Ellson, Jr. M. D. Office Gynecology. Pennsylvania M. J. June* 1957.

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The Month in Washington



Washington, D.C. — Several months in advance of the return of the 85th Congress for its election-year second session, influential figures in the field of health in both the executive branch and in Congress were being heard on what 1958 has in store for the medical profession.

Because of the roles they play in the Capitol, their views are worth more than passing notice. One is the chairman of the important health appropriations subcommittee of the House, Rep. John Fogarty (D., R.I.). He used as a forum for his prophecies the annual convention of the American Hospital Association.

Other prognostications came from Dr. Aims C. McGuinness, special assistant for health and medical affairs to Secretary Folsom of the Department of Health, Education, and Welfare. Dr. McGuinness spoke out at a dedication ceremony of a new chronic disease rehabilitation facility in Maine.

Mr. Fogarty places at the top of his predictions some action on federal construction aid to medical schools. The Rhode Island Democrat has his own bill on th subject, although there are others pending. Comments Mr. Fogarty: "...the shortage of health education facilities today is probably the most serious bottleneck in our whole medical system... These schools... fall far short of accommodating the fully qualified and competent young men and women in America who are anxious to train and qualify in medical, dental and public health fields."

The record of the past several years has shown that no member of the House is listened to more carefully when it comes to health than Mr. Fogarty. His philosophy in the health field is worth noting: "It is now generally accepted that the health of our people is a major national resource and that the government, therefore, has a direct responsibility for the health of everyone."

Dr. McGuinness also spoke out strongly for federal aid to medical schools. Failure to meet the needs of the schools, he told his audience, would be "the worst kind of economy." He feels that the administration proposal for $225 million in construction grants would bring classrooms and research laboratories "much closer to current and projected needs."

While neither man had any specific legislative proposals to make in the field, both foresee a growing role for hospitals in the practice of medicine. Dr. McGuiness put it this way: "General hospitals must broaden their services and achieve greater co-ordination. The term 'hospital care' should include not only bed care but diagnostic service as well as service to ambulatory patients."

Mr. Fogarty, looking ahead 25 years, said it was safe to predict that virtually every general hospital in the nation will be providing at least as much preventive service as curative service. "You are, in fact, moving closer each moment to the day when hospitals will be the focal point of health services for all of us, throughout our entire lives."

The same day that Mr. Fogarty was urging the hospitals to use the basic Hill-Burton hospital construction program to meet future health needs, the AHA House of Delegates approved a

(*Continued on page 32*)



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WASHINGTON (Continued)

set of legislative proposals to present to the next session.

They would accomplish the following: (1) extend the act for five years beyond June, 1959, (2) authorize matching Hill-Burton funds for renovation and repairs of hospital plants, (3) set up loan authority so that hospitals not desiring grant money could borrow construction and renovation funds at very low interest rates (from 1½ to 2%). The house also urged a grants program to hospitals with nursing schools and to other nurse institutions for professional education, exclusive of construction grants.

NOTES

One committee of Congress knows months in advance just exactly what it plans to do the day Congress reconvenes. The tax-writing House Ways and Means Committee has set hearings starting January 7 on possible tax reductions next year.

Included on the agenda will be testimony from various organizations on the Jenkins-Keogh bills for allowing tax deferments for money paid into retirement plans. The American Thrift Assembly, which is backed by the American Medical Association and other professional and business groups, plans to be heard at some time during the 30 days of hearings.

Veterans Administrator Harvey Higley believes that the public is losing interest in the veteran and his problems, and that some doctors no longer hesitate to attack medical care for veterans, particularly those with non-service-connected disabilities. Mr. Higley spoke at the annual American Legion convention.

Health directors of 21 American republics, holding their annual Pan American Sanitary Organization meeting here this fall, voted a $3 million budget for the Pan American Sanitary Bureau's 160-odd health projects for next year.

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Anxiety from information

There is a very real ethical question as to whether it is justifiable to utilize strongly anxiety provoking information to stimulate people to support research in a disease condition about which medicine is not yet in a position to recommend beneficial or corrective action. *Harold P. Halbert. Mass Communications and Health. Pub. Health News (New Jersey), Aug.* 1957.

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The Use of an Oral Hypoglycemic Agent as an Adjuvant in the Treatment of Diabetes Mellitus

LAWRENCE J. KNOX, M.D., CHARLES W. HARRISON, M.D., AND JOHN P. DOENGES, M.D., F.A.C.P.; OLNEY

IN 1942, Loubatieres,[1,2] while working with the sulfonamide compounds, found that certain of these agents had a hypogylcemic effect. These compounds were studied further by a group of investigators in Germany,[3,4,5] during the last several years, for their antidiabetic properties. It was found that the arylsulfonylureas had some practical application in the treatment of diabetes mellitus, and this finding has led to a widespread clinical interest in these compounds. It is the purpose of this paper to report the uses of one of these agents, tolbutamide (Orinase),* in the clinical management of diabetes.

Much remains to be learned as to how and why these arylsulfonylureas exert their influence on carbohydrate metabolism. Brown[8] found that Orinase had a mild but definite antithyroid effect in four of nine patients. Thorn[9] and his co-workers studied the effects of these compounds on a patient who had undergone hypophysectomy. The aminobenzene derivative produced a hypoglycemic effect and these findings suggested that a dependency of reaction between the arylsulfonylureas and the pituitary is unlikely. The decreased conversion of galactose or fructose to glucose during arylsulfonylurea action points to the liver as the source of action of this compound. It also suggests that selective interference with hepatic gluconeogenesis might significantly contribute to their hypoglycemic action.

Work done in animals by Ashworth, et. al.[6] suggests that the pancreas may be stimulated by the arylsulfonylureas. The influence is probably exerted through the beta cells of the Isle of Langerhans or is in part due to a reduction in action of hepatic "insulinase." Friedlich[7] and his group have shown in animals that the arylsulfonylureas decrease absorption of glucose from the gut.

In this study we were particularly interested in the usefulness of Orinase as an adjuvant in the treatment of out-patients. Forty diabetics were treated and observed clinically for a period ranging from seven to nine months. Special emphasis was placed on the need to evaluate the

From the Department of Medicine, The Olney Sanitarium Clinic, Olney, Illinois.

*Orinase supplied by Upjohn Company.

function of the hemopoietic system — thyroid, pancreas, and liver — in view of the possible toxic effects on these organs. We are also reporting four cases in which Orinase was used in selected patients who were undergoing elective surgery.

METHOD OF STUDY

The 40 patients treated on an out-patient basis were from a rural community. They were classified as mild and moderate diabetics. Orinase was started abruptly with prompt discontinuance of the insulin but diet and other medications were continued without any alterations. Blood sugars were obtained every other day for four times and were then obtained weekly until the dose of Orinase was adjusted. Complete blood counts also were obtained at reasonable intervals to determine any blood dyscrasias. Thymol turbidity, cholesterol, and protein-bound iodine determinations were done periodically to determine the effect of this drug on these systems.

Of the 40 patients in this study, 16 were males and 24 were females; the average age of the males was 58 and that of the females, 59. The duration of diabetes ranged from zero to nine years for the males, and zero to eight years for the females. At the onset of Orinase therapy, 32 of the patients were considered to be poorly controlled. The average dose employed during the entire treatment period was 1.6 grams daily for males and females, and dosage ranged from 0.5 gram to four grams daily.

The weight changes noted in this group are illustrated in Table 1. The greatest weight gain or loss did not exceed 10 pounds. There was no correlation between the weight change and alteration in blood cholesterols.

TABLE 1

Weight Changes	No. Patients	Aver. Change
Weight Gain	14	3.1 lbs.
Weight Loss	12	4.1 lbs.
Unchanged	14	——

In all patients, blood cholesterols were obtained initially and in 22, blood cholesterols were rechecked in three months. As noted in Table 2, the blood cholesterol was significantly elevated following Orinase therapy. The average increase was 39 milligrams per cent and the greatest increase was 250 milligrams per cent.

TABLE 2

	Number Of Cases	Average Initial Determination	Average Determination
Serum Cholesterol	22	211 mgm.%	250 mgm.%
Blood Sugar	40	198 mgm.%	169 mgm.%
Thymol Turbidity	45	1.9 units	1.6 units

In the latter instance, the patient exhibited no clinical manifestations in association with lipemia; however, in this patient, as well as in two others in which the blood cholesterol was elevated following therapy, a paradoxical protein-bound iodine was found. In each instance, the protein-bound iodine was slightly elevated.

The average initial blood sugar in this series was 198 milligrams per cent. The range of blood sugars was from 116 to 337. Twenty-seven of the patients were receiving insulin and 13 were not; however, those not on insulin had elevated blood sugars and glycosuria at the onset of therapy. The insulin range was from 10 to 40 units, with an average 23 units daily. Several of those not receiving insulin were new diabetics who were started on Orinase as their initial therapy. After 48 hours a consistent drop in blood sugar was noted. At the end of one week 10 patients were still considered to be inadequately controlled even though the blood sugar level was lower than the initial level. At the end of three months, eight patients were not completely controlled and in four of these, Orinase therapy was discontinued. In one patient therapy was stopped because of poor co-operation. In the remaining three, the poor control could be explained by dietary indiscretions or intercurrent infection, and in these therapy was continued.

At the end of three months the average blood sugar was 169 milligrams per cent. In patients who continued on treatment for three months, a level below 180 milligrams per cent was considered to be adequate control. It was not found necessary to discontinue therapy in any patient after three months, and approximately one-half of the cases have been on therapy for seven months.

In 10 cases, protein-bound iodine determinations were made three to four weeks after ther-

apy was instituted, and in nine of the 10 these were within the euthyroid range. One patient was found to have an elevated protein-bound iodine and clinically proved to be hyperthyroid. This developed while the patient was on Orinase therapy, which was continued without any other apparent complications and the hyperthyroidism responded to propylthiouracil. The combined therapy with these two drugs did not produce any appreciable change in the hemogram.

Complications were encountered infrequently with the exception of the four patients who became mildly acidotic, necessitating discontinuation of therapy. Only two other cases developed any clinical side effects. In one case, a diffuse maculopapular rash appeared on the extremities which was self-limiting and therapy was not interrupted. The other patient had hypoglycemic reactions manifested by nervousness, sweating, trembling, and prostration. He responded to glucose administration and reduction of Orinase dosage. Weekly complete blood counts were made in all patients and no abnormalities were found. Gastric intolerance was not encountered.

As a whole, the patients had no subjective complaints and many expressed a feeling of well-being, unsolicited.

With the exception of five cases in which the drug was discontinued for reasons previously mentioned, the results in the other 35 cases were considered good in 29 and fair in six[6]. In the latter cases, the blood sugar on occasion would range as high as 180 to 220, but none of these patients became acidotic or showed significant glycosuria. Despite the elevation of blood sugar, these patients felt well and preferred to continue with therapy. Frequent physical examinations revealed no objective changes in their clinical course.

During the course of this study four operations were performed; one was minor and the other three, including an amputation, an orthopedic procedure, and a Watkins interposition with a perineorrhaphy, were considered major procedures. The following represent the case reports of the four operations performed during this study.

Case No. 1: A. H., a 62 year old white female, had had mild diabetes for two years. She had been on 1.5 grams of Orinase daily for two months and was well controlled. She was admitted to the hospital on July 22, 1956 for a repair of a cystocele and rectocele with a Watkins interposition. On the day of operation the preoperative blood sugar was 152 milligrams per cent. She received 0.5 grams of Orinase the morning of the operation. The patient was operated on July 23, 1956 under Pentothal® and maintained on nitrous oxide and ether. The duration of the operation was one hour and 30 minutes. During the procedure, 1,000 cc. of 10 per cent glucose were administered and this was covered with 50 units of regular insulin in the fluids. The immediate postoperative blood sugar was 250 milligrams per cent and four hours postoperatively, the sugar was 57 milligrams per cent. There were no clinical signs of hypoglycemia, and 500 cc. of 5 per cent glucose were given with no insulin. The following morning the fasting blood sugar was 110 milligrams per cent and Orinase was continued. The postoperative course was uneventful.

Case No. 2: I. S., a 78 year old white female with diabetes of four years' duration, entered the Richland Memorial Hospital on February 21, 1957. She had been taking 1.5 grams of Orinase daily for five months. A uterine polyp and cervical polyp were removed by a dilatation and curettage on February 21, 1957. She received nitrous oxide anesthetic and remained under the anesthesia for 35 minutes. Preoperative blood sugar was 156. Postoperative urine was negative for sugar. The patient made an uneventful recovery from the operation, continued the Orinase as usual, and showed no signs of acidosis throughout her hospitalization. Her entire period of hospitalization was 24 hours. We considered this a minor procedure without incident.

Case No. 3: B. T., a 58 year old white female had had moderately severe diabetes for approximately ten years. She had taken as high as 40 units of insulin in the past for control of her diabetes, and at the onset of Orinase therapy she was on 30 units of N. P. H. insulin. She was admitted to the hospital on July 13, 1956, following an automobile accident, with multiple fractures, lacerations, and shock. She had a fractured pelvis and compound fractures of the tibia and fibula and was placed in a body cast. Orinase was started approximately three weeks later because of the difficulty in administering insulin. She was well regulated on Orinase for six weeks; however, at that time she had a psychotic episode which was felt to be unrelated to the Orinase therapy, but the drug was discontinued temporarily. She was on insulin treatment for three weeks and then Orinase was resumed without any adverse effect.

This patient had several operative procedures while on insulin therapy. On December 19, 1956, after Orinase was resumed, external skeletal fixation was removed under Pentothal anesthesia. Her preoperative blood sugar was 94 milligrams per cent and during surgery she received 1000 cc. of 10 per cent glucose. Her immediate postoperative blood sugar was 224 milligrams per cent and she received 20 units of regular insulin. Later in the day, her Orinase therapy was resumed and the following day her blood sugar was

94 milligrams per cent. On January 21, 1957, because of persistent menorrhagia, dilatation and curettage was done under intravenous Pentothal and nitrous oxide. Prior to surgery her blood sugar was 83 milligrams per cent and she received 1000 cc. of 10 per cent glucose during surgery. The blood sugar immediately after surgery was 271 milligrams per cent and one day postoperatively it was 103. The patient received no supplementary insulin, and the Orinase therapy was resumed two and one-half hours after operation. Her postoperative course was uneventful and she was discharged from the hospital on January 25, 1957.

Case No. 4: A. S., a 67 year old white male had been a moderately severe diabetic for 10 years and also had had coronary thrombosis and congestive heart failure. He had been on as high as 60 units of insulin daily, and at the onset of Orinase therapy he was receiving 35 units of N. P. H. On 2.0 grams of Orinase daily the urine became sugar free but the blood sugar ranged between 180 and 200 milligrams per cent. This patient was hospitalized repeatedly because of peripheral vascular disease with eventual diabetic gangrene of the toes. This reponded poorly to medical measures and amputation became imperative despite the patient's poor general condition.

On January 14, 1957 a mid-thigh amputation was done under refrigeration anesthesia augmented with hyoscine, morphine, and cactoid. The preoperative blood sugar was 271 milligrams per cent with a ++ glycosuria. The patient received his usual Orinase dosage the morning of operation. During surgery he received 1000 cc. of 5 per cent glucose with 20 units of regular insulin in the fluids. Immediately postoperatively the blood sugar was 438 milligrams per cent. The Orinase was resumed on the first postoperative day, and on the second day the blood sugar was 512 but the CO_2 combining power was normal. The temperature rose to 104 degrees, respirations became Chenye-Stokes in character, and there was evidence of consolidation in the left base. With the onset of the hyperpyrexia, the patient went into shock but there was no evidence of acidosis by either clinical or laboratory examinations. Because of the marked blood sugar elevation, insulin was resumed but the patient continued his downhill course and expired. It was felt that he had developed an atelectasis and pneumonia; however, an autopsy could not be obtained.

DISCUSSION

On the basis of the treatment of these 40 cases with the oral hypoglycemic agent, we feel that the out-patient care of a diabetic can be simplified. Certain features of this mode of therapy are invaluable. One of our cases, an elderly female and a long-standing diabetic with severe atrophy of the shoulder and thigh muscles from repeated insulin injections, was helped by the oral administration of the drug. Patients with a true sensitivity to insulin should find Orinase equally beneficial.

In this group, most of the patients were elderly and some had poor vision or other infirmities which made this type of therapy very applicable. With Orinase treatment less anxiety was experienced by the new diabetic and by those with a psychological "fear of the needle." The problem of maintenance of sterile technique is no longer a factor. When properly administered and controlled, there is a wide margin of safety with the oral route of administration. Even when acidosis did occur the onset was gradual and was detected easily. These patients went through the usual intercurrent infections with no more difficulty than one would expect with ordinary insulin therapy and no change of dosage was necessary.

Our experience with this group of diabetics follows that of similar groups. Juvenile diabetics and severe diabetics of long standing with large insulin requirements did not respond to this type of medication. The failures encountered in this series represented one juvenile diabetic and three severe diabetics, whose primary insulin dose was over 40 units daily. In this series, 72 per cent of the patients were controlled satisfactorily. Treatment was most successful in the elderly diabetic, whose insulin requirement was small and whose diabetes was of short duration.

The out-patient care of diabetes with Orinase therapy is attractive but attention must be called to certain obstacles. We are particularly impressed with the changes in the cholesterol determinations found in this series. The arteriosclerotic changes associated with diabetes are well known and the tendency toward increased lipemia may be of great significance. It is true that this group represents a small series and the serum cholesterol changes were not of great magnitude; however, the change constitutes a danger that warrants further investigation. Gross lipemia of the serum was noted in two cases without any other clinical manifestations.

The operated cases herein reported briefly show that the hypoglycemic agent can be used by itself and in conjunction with insulin, in a practical manner, in selected cases. Three of our operated cases received a general anesthetic, either inhalation or Pentothal. If the anesthetic is of short duration, and early oral management can be resumed, Orinase is entirely feasible. In these three cases the postoperative course was

uneventful and, in some respects, less complicated than those managed with insulin. An early postoperative rise in blood sugar was followed by a return to normal levels in 24 hours. Supplementary insulin was employed in two cases, but only to cover glucose given intravenously at operation. In the one patient who died postoperatively, it was not felt that Orinase played any part in his demise. He was poorly controlled before operation; however, at this time he had gangrene of the foot and all diabetics present a problem of control with this type of complication. Had it not been for the superimposed pulmonary infection, we feel that Orinase therapy would have proved adequate in conjunction with refrigeration anesthesia.

CONCLUSION

1. The oral hypoglycemic agent, Orinase, has been used with reasonable success in the outpatient care in 35 out of 40 cases of diabetes. Failures were experienced in severe and juvenile diabetics.

2. In over one-half of the cases, a rise in serum cholesterol was noted. The significance of this finding needs further study because of the relationship of lipemia to arteriosclerosis in diabetics.

3. Operation is possible during Orinase therapy, in selected cases, without significant alteration of diabetic control.

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Reading epilepsy

Primary reading epilepsy, a new syndrome delineated by Bickford and co-workers, is diagnosed by the history of a generalized grand mal seizure occurring only after reading. Fairly prolonged reading usually is necessary during which the patient experiences first a feeling as if the jaws were moving and then actual movement of the jaw is observed. Single, brief twitches of the jaw, increasing in frequency, warn the patient of an impending seizure. The process ceases if reading is stopped. The electroencephalogram is normal with the patient awake or asleep, and also with photic stimulation. But reading evokes bilaterally synchronous spike discharges in the tracing. *Harold Stevens, M.D. Reading Epilepsy. New England J. Med. July* 25, 1957.

The Prevention of Hyposenitization Reactions

Leonard H. Harris, M.D., Peoria

REACTIONS to antigens used in hyposensitization usually can be prevented or reduced to a minimum by taking adequate precautions. Even the infrequent but severe constitutional reactions can be controlled if adequate measures are instituted rapidly. The purpose of this paper is to discuss the pitfalls that lead to systemic reactions and to help you recognize, prevent, or control reactions that occur in hyposensitization.

We must arbitrarily omit more than casual reference to drug reactions, although in a large measure what will be said regarding hyposensitization reactions applies as well to reactions to drugs with regard to their causes, manifestations, and treatment.

There are several types of reactions that occur in antigen hyposensitization. The first, the local reaction, is a desirable response to treatment. Local reactions that are exceptionally large, however, should call for caution in any succeeding increments.

Mild systemic or constitutional reactions probably occur once in many hundreds of injections in an allergist's practice. Even then most of these occur in the exquisitely sensitive individuals receiving pollen or mold injections. If one recognizes that most reactions are mild and that many recur in the same individuals, then these sensitive people can be observed closely. By this means extra caution can be applied where it is needed and reason can replace unjustified fear of antigen treatment. Severe systemic or constitutional reactions of the immediate anaphylactic type may occur and be manifested as severe asthma, circulatory collapse, or generalized urticaria. This rare, but serious, type of reaction will be discussed later.

Ordinarily, if the patient is detained for 20 minutes after hyposensitization treatments, systemic reactions can be recognized immediately and treated. They may be manifested by itching of the throat, eyes, or palms; by sneezing or wheezing; or by urticaria. Less commonly one sees such symptoms as headache, exhaustion, uterine bleeding, or gastrointestinal upsets.

There is a form of systemic reaction that is not usually mentioned in the literature. It is insidious in onset and is seen in mold sensitive asthmatic children; here asthma flares up for a night or two after the injection and then recedes. Sometimes the pattern of reaction is so insidious that relationship to treatment is difficult to discern and is misinterpreted as just poor results.

Most of the causes of hyposensitization reactions might be termed preventable. A better understanding of the patient's tolerance, the potency of the antigen, and particularly an understanding of good hyposensitization planning and technique can reduce these difficulties to a minimum.[1,2,3,4,7]

Failure to recognize the individual's limit of tolerance is a prime pitfall. No two people have the same degree of tolerance to an antigen; trying to fit all patients into a standard schedule can lead only to failure. In fact, a patient's tolerance may vary with different antigens, it may vary from year to year, and at various times of the year. Some persons tend to have more systemic reactions than others because their limit of tolerance is relatively fixed.

Many errors and pitfalls can arise in hyposensitization techniques that result in systemic reactions. There may be an error in the starting dose, an error in giving too large a dose or too rapid an increment, an error in too long an interval between treatment, or an error in giving the wrong dilution or extract.

An important safeguard in technique is the matter of pulling back on the plunger before making an injection, to guard against accidental intravenous injection. Yet I cannot dispel the disquieting impression that I have observed one or two so-called "intravenous-type" reactions despite this safeguard.

A tourniquet can be a doctor's best friend but it is a serious pitfall to render a tourni-

quet useless. No tests or injections should be given on any site on the arm that does not allow the effective use of a tourniquet. The deltoid and buttocks are therefore unsafe areas for treatment and the back is unsafe for intradermal testing.

Van Arsdel and Sherman[13] analyzed the incidence of constitutional reactions from hyposensitization treatments and from intradermal skin tests in a 20 year period involving 8,706 patients seen at Roosevelt Hospital, New York. They found that while systemic reactions occurred only once in 700 injections on the average, the pollen sensitive group had 95% of all the constitutional reactions. They found that 15% of the pollen group had at least one systemic reaction. They reported only five mold constitutionals in 8,700 patients. In our hands, systemic reactions with mold extracts poses our biggest problem. About 40% of all our patients are mold sensitive and 19% of these mold sensitive patients had one or more constitutional reactions.

Van Arsdel and Sherman state that about one half of all reactions were so mild they required oral if any medication. About 40% had moderate reactions that required epinephrine for relief. Only 10% of all the constitutional reactions were severe enough to require repeated epinephrine or prolonged treatment with oxygen or other measures.

In analyzing the causes of constitutional reactions to treatment they rank causes in this order:

1. Failure to reduce treatment dose adequately during or after the pollen season, 203 cases.
2. Attempting to exceed the patient's indicated tolerance, 153 cases.
3. Too great an increase in dosage, 88 cases.
4. Cumulative effect of maintenance doses or too long an interval between treatments, 92 cases.
5. Failure to reduce dose when changing to new extract, 14 cases.
6. Giving high concentration or wrong pollen by error, 10 cases.
7. Possible intravenous injection of extracts, 4 cases.

The reactivity and poteney of certain extracts can be a factor in the produetion of constitutional reactions. Certain common extraets are known to be very potent antigens and should be used with caution, not only in hyposensitization but in testing as well. The more potent ones include ragweed, Alternaria, animal danders, cottonseed, flaxseed, fish, nuts, eggs, and buckwheat. Castor bean is so potent that most allergists do not use it even for scratch testing. Many others do not use cottonseed intradermally or for treatment.

Delayed or immediate reactions to sensitizing ehemieals, drugs, and serums can at times be prevented by obtaining a history of previous trouble and by administering a substitute less likely to react in the individual[5,6] such as using tetracycline instead of penicillin or bovine instead of horse serum. At other times there seems to be no adequate way of anticipating which patient will react to what drug. The threat of reactions to horse serum can be reduced by the prophylaetic immunization with tetanus toxoid. Tetanus antitoxin should be used with extreme caution in any allergic individual or where a story of prior reaction is elicited.

As a screening method, skin testing with drugs, serums, and antibiotics leaves much to be desired. Skin tests are worthless or misleading with aspirin, morphine, eodeine, iodides, contrast media, and procain.[5] It is foolhardy to doubt a patient's story of allergy or intolerance to aspirin or other drugs. Severe asthma or other unpleasant sequelae may result. Positive skin tests may at times be obtained with serums and penicillin but the results with such tests often are misleading[9,17] or misinterpreted. A negative test with horse serum or penicillin is no assurance that systemic reactions may not occur. However, a positive skin reaction of the immediate type using 1/20 cc. of a weak dilution of serum or penicillin should alert one to the potential dangers of a severe anaphylactic reaction upon further treatment. A syringe filled with epinephrine on the treatment tray is still the best safeguard.[17]

As a commentary on the false security of a negative sensitivity test, Pendergrass,[10] in reviewing four million urograms, found 25 cases of immediate death attributed to contrast media. Of these deaths, 15 had had negative sensitivity tests.

The factor of pregnancy in its relationship to hyposensitization treatment is worthy of

mention. Pregnancy is an indication for caution but is not a contraindication for hyposensitization treatment. The only instance of vaginal bleeding as a manifestation of overdosage that I have seen occurred in a nonpregnant single woman. This single experience points up the theoretical possibility of uterine contractions in the pregnant allergic woman and the justification for extra precaution in hyposensitization of the pregnant.

TREATMENT OF REACTIONS

When hyposensitization programs are carried out with the foregoing precautions, systemic reactions are less likely to occur or usually are mild and readily controlled when promptly treated. For mild reactions consisting of sneezing, chest tightness, itching, or urticaria, the subcutaneous use of 1/3 cc. of epinephrine 1-1000 or antihistamic solutions often is adequate. In fact, the oral use of ephedrine or antihistaminic often suffices. But epinephrine 1-1000 must always be ready for use on the treatment table if need should arise.

In an effort to prevent allergic reactions, antihistaminic solutions have been combined with antigen. This has been popularized by Simon, Marietta, and Silbert in pollen therapy[11,14,15] and has been used to prevent penicillin reactions by Simon and others.[11] When antihistamines are combined with pollen, both of which are relatively short acting, the reactions may be reduced in size and number but too often local and systemic reactions are merely delayed by this method. Too frequently reactions occur after the patient has left the doctor's office and is out of contact with immediate medical care. Any advantage of increased dose tolerance obtained by this method[11,12] now seems overweighed by the threat of delayed reaction after the patient has left contact. In fact an interesting unconfirmed report by Drassinower[16] suggests that constitutional reactions, at least with house dust, can be controlled as well or better with oral antihistaminics than by the combined antigen- antihistaminic solution method.

Every physician who administers allergenic extracts must recognize that despite every caution, severe constitutional reactions can occur. True of allergens just as with serums, antibiotics, or contrast media, severe reactions can occur that demand immediate and adequate treatment.

Systemic reactions that come on in a few minutes are due probably to accidental seepage or injection into the venous circulation. An immediate severe constitutional reaction is potentially dangerous and always calls for immediate emergency treatment. It may manifest itself as sudden air hunger, a sense of suffocation or choking, asthma, circulatory collapse, shock, or generalized flush. Epinephrine 1-1000, (0.5 cc. or more), depending on the severity, should be given immediately. Epinephrine and a tourniquet should be within arm's reach when antigens are administered. A tourniquet should be placed firmly above the site of the injection of antigen and an additional 1/3 cc. epinephrine should be injected below the tourniquet into the antigen site. There may be little or no local swelling if absorption has been excessively rapid. When the reaction subsides, the tourniquet may be slowly removed. These steps will control all but the most severe and desperate situations, in which case it may be necessary to repeat the epinephrine, to give injectable antihistaminic solutions, to administer aminophyllin intravenously, or to give ACTH intramuscularly or intravenously. After improvement is apparent the follow-up treatment with oral medication is similar to the measures used in controlling mild systemic reactions.

These measures should be carried out quickly but calmly and quietly without upsetting an already disturbed patient. After the initial use of epinephrine and the application of a tourniquet, the use of other more drastic measures, unless indicated, may serve only to increase the patient's discomfort and hence should be reserved for those exceedingly rare but necessary circumstances.

The management of systemic reactions from allergens differs at times from the management of drug reactions, particularly when the latter may be delayed and prolonged. When relief is desired for longer periods than may be afforded by epinephrine or antihistaminics, resort may be had to ACTH or prednisone. It has been established in animals that corticotropins and corticosteroids will prevent artificially induced anaphylactic reactions. ACTH and prednisone have been used in the treatment of serum sickness type reactions, drug reactions, and in severe hyposensitization reactions. However, no controlled statis-

tical studies have been made to evaluate their usefulness in the prevention of immediate or delayed allergic reactions due to drugs or other allergenic materials.

SUMMARY

Allergic reactions following hyposensitization can be prevented or minimized by careful allergic management and by avoiding certain pitfalls in technique. Mild systemic reactions can be controlled quickly if treated promptly. Every physician should be alert to the best methods of treating severe immediate constitutional reactions and should know when best to use epinephrine and a tourniquet or other measures including injectable antihistaminics, aminophyllin, ACTH, and the steroids.

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Time needed for headache

Wolff's long interest in headaches and his great experience must lend weight to his general conclusions about their management. "More than 90 per cent of people with headache have their headache as a result of vascular disturbances, sustained skeletal muscle contraction about the head, and vasomotor disturbances within the nose. . . . .Two people out of three with this vascular-muscle-tension headache combination can be helped greatly by any physician who is interested in human problems, and willing to spend a minimum of time with his patients in reviewing them with him." It is notable that one who has spent so much time on the study of headache by experimental methods should arrive at such very human conclusions. Perhaps a strictly scientific outlook and a human approach to clinical problems are not as incompatible as they are sometimes made to appear. And we may hope that more clinical investigators will need to be attracted to this kind of investigation. *Editorial. Headache Mechanisms. Brit. M. J. Sept.* 14, 1957.

Cerebral Angiography

Fay H. Squire, M.D., Chicago

EGAS MONIZ in 1927 first described injections of contrast media into the vessels of the brain and demonstrated them on X-ray films. He and his pupils were the first to point out the features of the vascular lesions and various brain tumors outlined by cerebral angiography. His work was not generally accepted in this country until about 10 years later, when the procedure came into general use.

The technique used has varied some since first introduced, but the prime object has been to obtain X-ray films showing the filling of the arteries, capillaries and veins of the brain. The open and closed methods of injection have been used. We now use the percutaneous method. An 18 gauge needle is inserted into the common carotid artery under general anesthesia (sodium Pentothal®). Thorotrast Hypaque® 50 per cent and Diodrast® 35 per cent have been used as contrast media. We use Diodrast 35 per cent. Ten cc. are injected with a Luer-Lok syringe (metal plunger) as rapidly as possible. As the last two cc. are injected, the X-ray series is started. We use a Sanchez-Perez mutiple exposure machine that takes one film every half second for six films. This is adequate to demonstrate the arterial and venous phase of the cerebral circulation. Films are made in the lateral projections and then, with a second injection, in the anterior-posterior position. Both sides have been injected in one day, but usually only one side is injected. A tracheal airway usually is in place before injection is started to prevent respiratory embarrassment should the contrast medium be injected outside of the artery. General anesthesia is used to eliminate local discomfort and decrease cerebral reaction.

The anatomy of the cerebral vessels is fairly constant.

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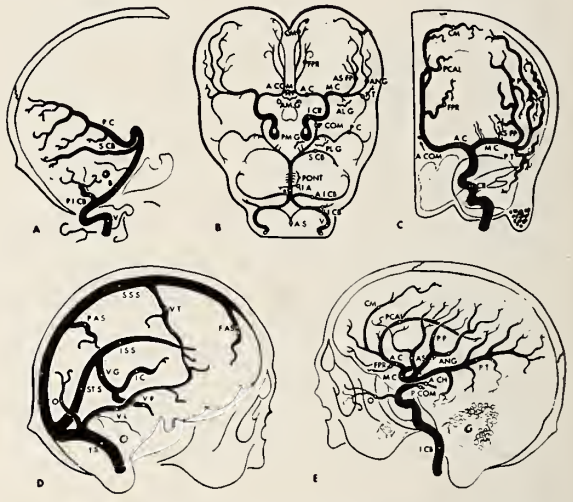


Figure 1 (from chart of Intercerebral Circulation published by the Eastman Kodak Company)
The internal carotid artery traverses the skull through a canal in the petrous portion of the temporal bone and passes forward opposite the sella turcica. The branches of the internal carotid artery given off in the brain are in order of their origin:

1. **Ophthalmic**
2. **Posterior communicating**
3. **Anterior choroidal**
4. **Anterior cerebral**
5. **Middle cerebral**

The anterior cerebral artery gives off:

1. **Anterior communicating**
2. **Frontopolar**
3. **Callosomarginal**
4. **Pericallosal**

The middle cerebral artery gives origin to the Sylvian fissure group of arteries:

1. **Ascending frontoparietal**
2. **Posterior parietal**
3. **Angular**
4. **Posterior temporal**

The posterior cerebral arteries usually are not visualized when the carotid artery is injected. They arise from the basilar artery and are seen when the vertebral arteries are injected.
The major venous channels are:

1. **The superior sagittal sinus, supplied by:**
   a. **Frontal ascending vein**

b. Anastomatic vein of Trolard (Rolandic Vein)
c. Parietal ascending vein

2. The inferior sagittal sinus which drains into the straight sinus.
3. The internal cerebral vein and the vein of Rosenthal unite to form the Great Vein of Galen, which joins the straight sinus at its junction with the inferior sagittal sinus.

These veins all drain into the transverse sinus which also receives blood from:

1. The communicating temporal vein of Labbe
2. The descending temporal occipital.

For the purpose of angiography the pathology of the brain may be divided into the vascular abnormalities and the space-occupying lesions. The vascular lesions comprise the arteriovenous communications, angiomata, aneurysms, and arteriosclerotic changes. Angiomata are characterized by abnormally large, tortuous arteries which form a plexus that joins with large tortuous veins. The contrast medium often is pooled in these vessels after it has left the normal vascular channels. These usually occur on the surface of the brain and do not displace the uninvolved cerebral vessels.



Figure 2. This is a 35 year old female who had two previous attacks of subarachnoid hemorrhage one year apart. A large tortuous vessel is demonstrated within an angioma. The middle cerebral artery is filled normally and not displaced. The anterior cerebral artery is not visualized.

Aneurysms usually arise from the arteries about the circle of Willis. They appear as small or large rounded areas. They may fill completely with contrast medium or be partially or totally filled with a clot and thus occasionally are not visualized.

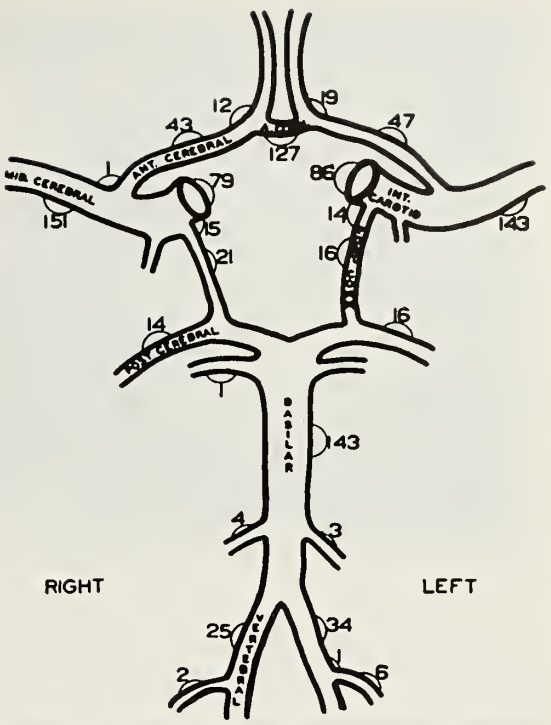


Figure 3 Arch. Neurol. & Psychiat. McDonald and Korb, (Aug.) 1939.
This shows the location of 1,023 aneurysms about the circle of Willis. It can be seen that the majority occur in branches of the internal carotid artery.



Figure 4 This demonstrates a typical aneurysm at a common location, the anterior communicating artery.

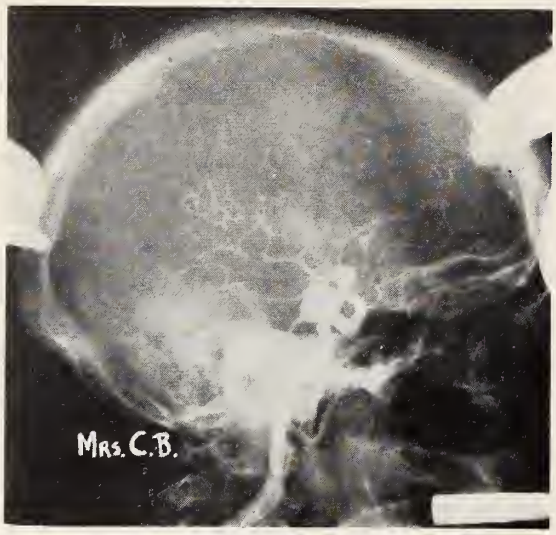


Figure 5a. This is the lateral arteriogram on a 63 year old woman who experienced a drooping eyelid and pain in the forehead of three days' duration. It shows a round aneurysm filled from the internal carotid artery in the region of the sella turcica. The anterior and middle cerebral arteries are filled normally.



Figure 5b. This is the A-P view made on the same day and demonstrates the aneurysm just lateral to the sella.

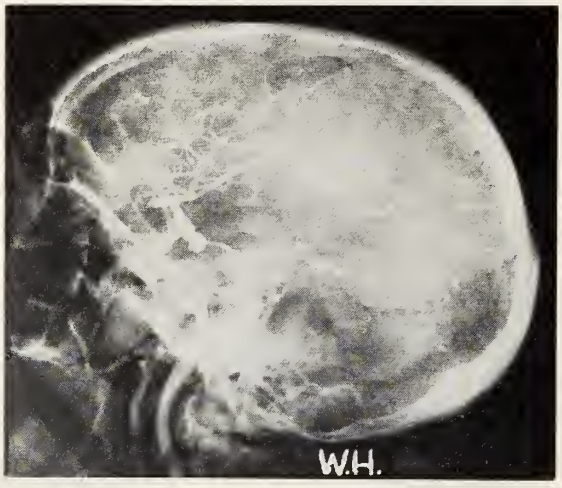


Figure 6. This is the lateral view of a 51 year old male who had experienced headache and ptosis of the left lid for four months. A small aneurysm of the posterior communicating artery is demonstrated. The posterior cerebral artery was also filled at this injection.



Figure 7. This shows a giant aneurysm of the internal carotid artery in a 63 year old female. On the plain film erosion of the bones about the sella had been demonstrated. Occasionally these aneurysms may also be visualized on plain films if the wall is calcified.

Arteriosclerotic changes in the vessels of the brain may be generalized showing irregular narrowing of the lumen or localized with narrowing which may be extensive enough to completely occlude the lumen.

Space-occupying lesions of the brain, such as tumors, cysts, abscesses or hematomas may cause the normally tortuous cerebral arteries and veins to be displaced, separated, thinned or straightened.

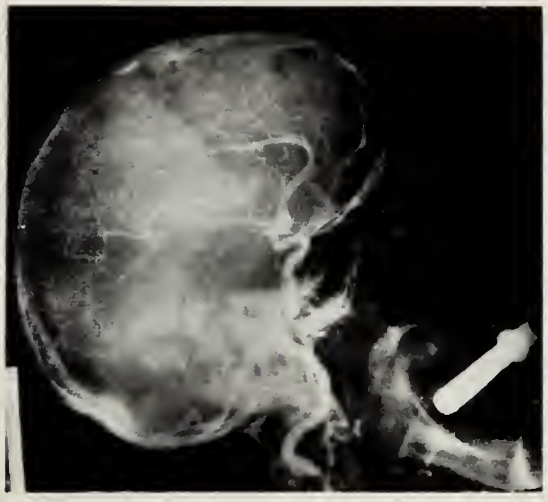


Figure 8. For the past two years this patient noticed blurring of vision, diplopia and dizziness. For the past three to four weeks there was transient numbness of the entire right side, lasting 10-15 minutes. Carotid arteriogram shows a narrowing at the junction of the internal and external carotid arteries.



Figure 9. This shows the venous phase of a carotid injection of a 60 year old male who sustained a head injury 5 weeks previously. He had developed a right hemiparesis. The veins of the left parietal region are displaced medially and downward by an avascular mass. A hematoma was subsequently drained.

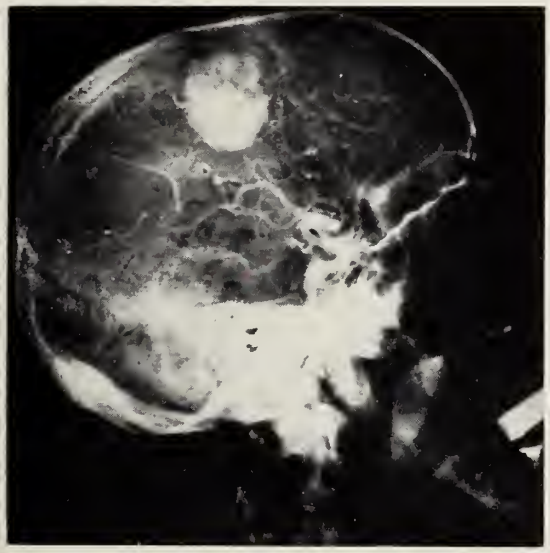


Figure 10. This is a lateral arteriogram of a patient with a 1½ year history of vertigo and pains in the left leg. This demonstrates a circumscribed tumor with typical "tumor stain" of a meningioma. At surgery this was a parasagittal meningioma. An anterior-posterior arteriogram should have been done to demonstrate the exact location and displacement of the vessels.



Figure 11. This is a patient with an 8 week history of dysphasia and right hemiparesis. It shows the venous phase of the lateral arteriogram, and demonstrates rather typically the vascularity within a glioblastoma multiforme.

Frontal lobe tumors displace the anterior cerebral artery across the midline and straighten out its tortuosity. The middle cerebral artery is displaced downward, and the carotid siphon is displaced downward and backward.

Parietal lobe tumors situated anteriorly push the anterior cerebral artery beyond the midline and displace the middle cerebral group downward. Parietal lobe tumors situated posteriorly push the pericallosal and callosomarginal arter-

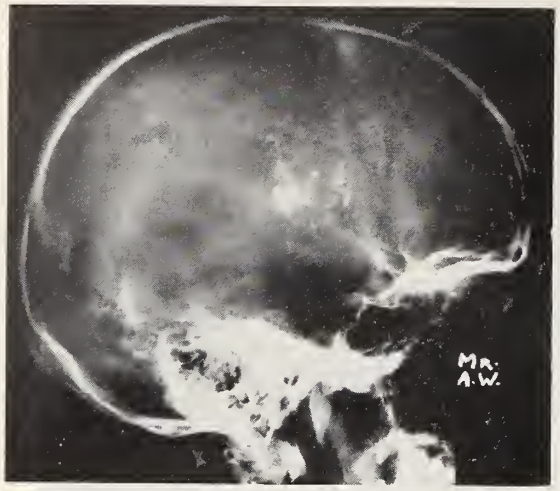


Figure 12a This plain film shows calcification of the right parietal region.

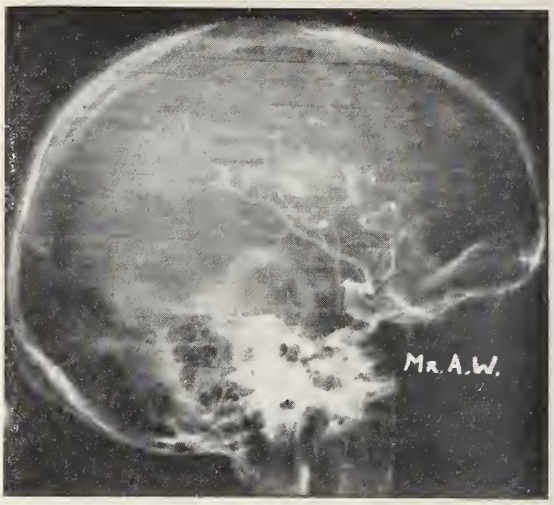


Figure 12b Right carotid arteriogram shows vessels coursing around the calcified area. A baseball sized oligodendroglioma was removed surgically from the right temporal lobe.

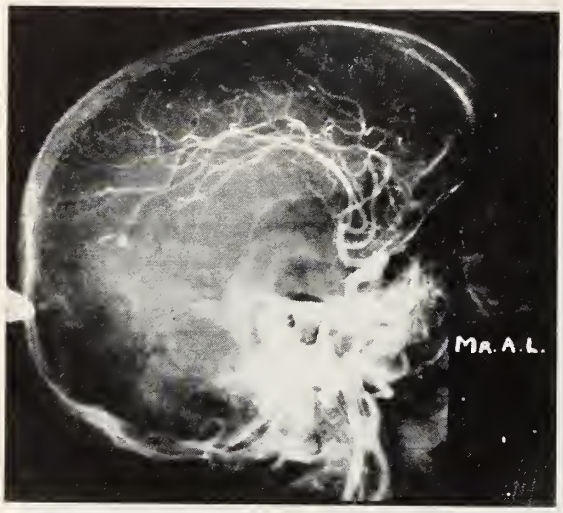


Figure 13 Patient had a left mastoidectomy and was placed on antibiotics. Six weeks later patient experienced an episode of unconsciousness, vomiting, dizziness, and severe headache. Film shows a brain abscess in the left parietal region, elevating the Sylvian fissure group of arteries.

ies across the midline.

Temporal lobe tumors elevate the middle cerebral group and straighten the carotid siphon.

Certain types of tumors may also be identified and localized by their internal blood supply.

Meningiomas are circumscribed tumors situated on the surface of the brain. They have a rich blood supply from the external and internal carotid arteries. Small brush-like arteries are visualized entering the tumor and forming capillary circulation within the meningioma. This has been called "tumor stain." The adjacent arteries are distended and curved around the tumors. The veins are short, large in calibre, and follow an abnormal course.

Glioblastomas are infiltrating neoplasms, relatively avascular and often show large areas of necrosis. They are surrounded by edematous brain. The blood vessels are poorly formed and small vessels within the tumor show fusiform and irregular dilatations. There is no uniform capillary opacity.

Astrocytomas usually are extensive growths, diffusely infiltrating the white matter of the brain. They cause stretching and spreading of the large cerebral arteries.

Cysts, hematomas, abscesses, and cholesteatomas are circumscribed and show an absence of vascularity. Other brain tumors and metastatic tumors may resemble any of the above.

We have not studied tumors of the posterior fossa by cerebral arteriography because we believe that more information can be obtained by air studies.

In conclusion, cerebral angiography proved a valuable and safe procedure in the localization and identification of tumors and vascular anomalies of the brain.

1753 W. Congress St.

Placebos —

A Panel On The Theoretical And Practical Implications of Their Use In Experimental And Clinical Medicine

EDMUND F. FOLEY, M.D., PROFESSOR OF MEDICINE.
ALAN K. ROSENWALD, PH.D., ASSOCIATE PROFESSOR OF PSYCHOLOGY.
CEDRIC M. SMITH, M.D., ASSISTANT PROFESSOR OF PHARMACOLOGY.

Doctor Samter: Placebos are ancient tools of medicine, but recent work on their potential has forced us to re-evaluate our simple concept that they represent inert controls for effective drugs. It might be well to begin today's Seminar with a definition, and to ask Doctor Smith: "What are placebos?"

Doctor Smith: The word "placebo" itself is the equivalent in Latin of the phrase "I will please". It may be defined as a chemical substance with negligible pharmacological activity which is given to the patient to please or comfort him. However, the use of the term has grown to include relatively inert substances (or such preparations as the solvent for an "active" agent) used as a "control" or "blank" in investigative procedures assessing an agent's effects. Another characteristic of a placebo is that its effects do not follow the dose-effect relationship which is characteristic for any given "active agent." Perhaps it would be advisable to limit the use of the word placebo to medication or procedures used to please or impress the patient and use such terms as "control," blank, "inert substance" to describe the controls in a study of drug effects.

It is not within the realm of this discussion to outline in detail experimental design, but I would like to mention that it is apparent that the more complex the study, or the experimental situation, the more difficult the assessment of the "control" response becomes. Certainly whenever the criteria of drug effect are subjective, the "double-blind" study is required to prevent any bias of the observer or subject from influencing the results.

Doctor Samter: Do you suggest that placebo is less important in tests of objective effects of drugs than in tests of subjective responses?

Doctor Smith: In all experiments in which the response is assessed by subjective evaluation, a placebo control is absolutely necessary.

Doctor Frenster: Are placebos required in animal experiments?

Doctor Smith: All experiments require controls. For example, when testing antiemetics, emesis is induced by such means as injecting apomorphine in dogs. As testing continues a conditioned reflex can become established so that simply the injection will cause emesis. Proper design, including random insertion of control injections of solvent only, prevents the conditioning from occurring.

Doctor Adrian M. Ostfeld, Assistant Professor of Preventive Medicine: We must also consider the "semi-objective" end point. Blood pressure readings seem objective. And yet, Shapiro of Southwestern Medical School reports of his enthusiasm for Veriloid where, in a space of six months, he found standard doses to give standard predictable blood pressure drops. He was then absent from the study a while and returned with his former enthusiasm replaced by depres-

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sion and a less avid approach to the study. Promptly, he saw the patient's blood pressure return to pre-treatment levels. Here, we see that the physician's attitude can sometimes influence objective findings too.

Doctor Smith: A certain variable percentage of individuals will "react" to administration of a placebo. The presence of these "placebo reactors" in a group of individuals may obscure the actual drug effects. When these individuals are eliminated in the analysis of the data, differences between drugs and between drug and control can be much more readily determined.

Doctor Walter S. Wood, Instructor in Medicine: In testing anti-hypertensive agents, Corcoran and his group have abandoned placebos. Not only did they find side effects making drug and placebo groups obvious to the observer, but also found comparison of drugs impossible without instructing their patients in possible side effects.

Doctor Samter: It is obvious then that placebo has a definite place and certain limitations in the evaluation of drugs. Doctor Foley, would you outline the role of placebo in therapy?

Doctor Foley: Consider the day lost on which one does not learn something. Today I learned that placebo means to please or placate, when since my high school latin days I was under the delusion that it meant "I believe." Yet, I was not too wrong because placation implies faith, trust and belief.

Doctor Smith has succinctly defined placebo and has indicated the areas in which it is employed. In clinical medicine, placebos are used in an attempt to establish a degree of equanimity in the patient, and to this end such a therapeutic device is directed toward forming in the patient a feeling of significance, a measure of safety, a sense of security and of recognition. The mode of action is by suggestion, and the degree of success is reflected in the depth of the belief developed in the patient. Placebo therapy is literally a form of faith healing which strengthens the patient-physician relationship.

The elements involved in the employment of placebo therapy are the patient, the physician, the place, the devices and the public.

The physician is the personal representative of the medical profession and is expected to bring to the patient's bedside all the knowledge, skills and abilities of medicine. These he is supposed to display by what is known as his manner (bedside manner—dusting off an old cliche) for the patient's scrutiny. The result of this scrutiny whether it is momentary or over a period of time results in trust and belief of the patient in the doctor, a basic requirement. The degree of confidence which the doctor can create, the amount of reassurance which he can inspire vastly influences the success of therapy. A broken leg or a broken heart will heal quicker, more comfortably and with less aftermath in the hands of a skillful artisan rather than a trite technician.

The patient's willingness to seek help means his recognition of something wrong and his want of help and reassurance. As he is being examined, he examines the doctor with a trusting or skeptical eye — a placebo reactor or non-reactor. In response to the doctor's opening question, "What seems to be your trouble?" the defiant answer, "That's for you to find out," or the endless recitation of intimate trivia read from a yard long foolscap from which the physician must ferret out significant clews of an elusive malady or identify them as the result of a disordered personality, again distinguishes the non-reactor from the reactor.

The place — compare the environment of a busy doctor's office over the corner drug store with a waiting room crowded with restless patients and wailing infants, an examination under pressure interrupted by a jangling telephone: compare this with the careful and leisurely examination in the quiet dignity of the Research and Educational Hospital when the patient has the benefit of searching scrutiny from all angles and through all orifices.

Public opinion: Because of the spectacular advancement of medical know-how and the dissemination of the success to the public, confidence in the professor has been awakened. Formerly, the chief therapy was placebo therapy, administered by the frocked and bearded gentleman who arrived via the horse and buggy. Now public opinion expects and demands complete examinations, and aggressive therapy as outlined in the medical gossip columns, Readers Digest, television and by word of mouth. Gone is the ritualistic garb and bag, accepted is the younger man equipped with the latest methods, sport clothes, crew cut, pipe and Jaguar.

Conditions for the use of placebos:

1. Time gaining — here placebos are used in the form of the tincture of patience to placate the patient while diagnostic procedures are being carried out which would lead to a definitive diagnosis and specific therapeutic indications or to placate the patient while a malady with a known course runs itself out.

Some patients depend on their crutch even after their broken leg has healed, some cannot give up their wrist bands, sacroiliac belt, and jock straps. These devices placate them. The factor of dependence requires placebo therapy or brutal frankness.

One of the means of withdrawing a procedure to which a patient has become addicted whether narcotic or physics is substitution of an inert substance.

In what forms do our placebos come?

1. *Oral* — the former nauseating mixtures such as tincture of Valerian have given way to polka dot pills and capsules, so pretty that they resemble gems. They must have a good effect.

2. *"Shots"* — iron, "steel", liver, "hot flashes" or "change of life."

3. *Devices* — diathermy, red lights, blue lights, supporters, and impression machinery.

4. *Surgical* — facelifting and other cosmetic procedures.

5. *Expensive, disciplinary regimen* — after spending thousands of dollars on fancy trips to tropical shores where he may eat only eel meat, our patient *has* to feel better.

6. *Spectacular* — procedures instituted with "Pomp & Circumstance" and carried out with all the ritual of a three ring circus must make a weighty impression on the patient.

All these procedures placate the patient and form the basis for placebo therapy.

Doctor Samter: Then, you widen the scope of placebo to include many impressive procedures as long as they are used without specific indication? It is, perhaps, only a question of semantics, but Doctor Smith included the term inert in his definition of placebo.

Doctor Foley: Your question requires a redefinition of "inert." We have placebos which the physician knows are inert, but the patient does not; but we have also agents now assumed to be effective which will, in ten years prove to have been only placebos. As an answer, I might say that I use placebo — inert or not — to help the patient "save face."

Doctor William R. Best, Assistant Professor of Medicine: In a patient with rheumatoid arthritis, should we inject an inert substance such as B_{12} rather than potentially toxic gold salts?

Doctor Foley: Yes, particularly since I suspect that gold itself is not much more than placebo.

Doctor Nicholas J. Cotsonas, Jr., Assistant Professor of Medicine: Doctor Foley, are you using your inert substance to save time; or do you imply that this act of injection is in itself beneficial in the overall course of therapy?

Doctor Foley: It helps.

Doctor Ostfeld: Knowing the patient, allows us to tailor our therapy and select the right placebo. The sophisticate requires entirely different overall management from the dock hand.

Doctor Harry A. Bliss; Assistant Professor of Medicine: It has been my feeling that we can often obviate the need for placebo by carefully explaining the functional component of disease to an intelligent patient. Is the less intelligent patient a better subject for treatment with long-term placebos?

Doctor Foley: In my experience, the patient's intellect has little, if any influence on the therapeutic results of either placebo or explanation.

Doctor Samter: Doctor Foley has classified his patients in several groups which may or may not respond to placebos. Doctor Rosenwald, can you as a psychologist offer any explanation for this variation in response; and, perhaps, suggest any means to predict it?

Doctor Rosenwald: First, let me say that in reviewing the literature on this subject, I was impressed by the writers' need to define "placebo." I am surprised by this undue concern over the semantics of the word which seems to me tangential to the current problems of placebo therapy. I also believe that in an ideal placebo study, the physician conducting the study should not know whether any of the agents being used is placebo. His foreknowledge should be no greater than that of the patient being examined.

Beecher found that about one-third of the population will react to placebo as though it were a potent drug. He also noted that placebo effect is greater if the patient is more distressed.

Stewart Wolf, however, noted that placebo effect may be great (at times greater than with the specific drug) when the patient is not tense, but is psychologically predisposed to receive treatment and if the patient is distressed about something or other he may be non-reactive to placebo.

Lasagna studied 160-plus patients with postoperative pain and isolated 27 patients from this group who either always or never reacted to placebo. Eleven patients were "reactors" and sixteen were "non-reactors." The non-reactor may even have symptoms exacerbated by placebo or by potent drug as well. In his study of these two groups, Lasagna found the reactors had less formal education, greater happiness with hospital experiences, more co-operation with procedures, were greater conversationalists, and had more somatic symptoms. They were more anxious and presumably less overtly hostile than the non-reactors. Their anxiety was diverted to somatic complaints. The number of Rorschach responses was considerably below average for both groups whose intelligence level was inferred as average. The non-reactors gave fewest responses; there are hints in the data which support the inference that these non-reactors were depressed and could not "afford" relief from pain.

In conducting any investigation to determine propensity for reaction to placebo therapy, one would first of all use the double-blind techniques. Multiple placebos of varying size, color, and route of administration would be used to randomize the method of administration of placebo and their various forms. The procedures of placebo administration, verbal comments to patient and finally, observation of response, would all need some degree of standardization. The physician-observer would then separate the placebo reactors and non-reactors by their clinical reactions to drug and placebo. The psychologist would attempt on the basis of the psychological test only and without benefit of the clinical reactions to separate the reactors from the non-reactors. If discrimination between the two groups proves possible, the factors in psychological test performance which appear to differentiate reactor from non-reactor could be validated by a new study which would seek to predict or isolate the reactors from non-reactors to placebo and potent drug. If, on the other hand, discrimination appears unsuccessful, the psychologist could review both sets of data, the clinical and psychological, to seek new criteria for prediction.

I am certain that the difficulties of conducting such experiments conclusively are apparent, but the suggestions represent, I believe, a nucleus for the study of a placebo person.

Doctor Samter: Doctor Rosenwald, you have at the same time enlightened us and complicated our problems. We must use placebo in our studies, but in order to make our conclusions acceptable, we must differentiate reactor from non-reactor. Is our own knowledge of the placebo person sufficiently secure to be included in our investigative program; or can we still afford to ignore it in our current studies?

Doctor Rosenwald: I think not. On the experimental side, your conclusions will be criticized unless you distinguish between the two groups. On the practical side, the advantage is obvious. Placebos will be given in medical practice and there is, I feel, real value in being able to predict beforehand which of your patients will respond to placebo therapy.

Doctor Frenster: The rational place for placebos in investigation has been established beyond doubt. I do not fully understand the rationale of placebo in the therapy of functional disease, Doctor Foley.

Doctor Foley: Functional disease indicates that the patient is aware of a change in function of some organ this awareness can be strongly influenced by placebo therapy. If at the base of it, however, we find some outside stimulus such as a nagging mother-in-law, we need more than a pretty pill. We cannot cure without a diagnosis. I am old-fashioned enough to follow James' philosophy. It isn't fear which gives tremor, dry mouth, and palpitation. The patient becomes frightened only when he experiences the altered function: he needs medication.

Doctor Wood: Doctor Samter, most residents here work some time in your Allergy Clinic and do hundreds of skin tests. Is this placebo?

Doctor Samter: It is getting late, and I refuse to be baited.

Doctor Smith: Doctor Foley, won't you comment on the danger of placebo therapy?

Doctor Foley: It might sound too simple, but complacency and smugness which substitute placebo where effective therapy is needed are the only dangers.

Clinical Lesions of the Oculomotor Nerve

Joseph E. Alfano, M.D., Chicago

THE oculomotor nerve arises from the oculomotor nuclei which comprise two large masses of cells, forming a V, lying in the central gray matter in the mesencephalon below the superior calliculus, beneath the acqueduct of Sylvius.

The nucleus is 5 to 6 mm. long. At the extreme anterior end of the nuclei is another paired group of cells of smaller size known as the Edinger-Westphal nuclei. A single group of cells lies in the middle of the V and is know as Perlia's nucleus.

From the experimental and certain clinical evidence available the frontal portions of the oculomotor nuclei function in elevating the eyes together with the lids, and that the caudal parts of the nuclei are related to downward movements of the eyes. The mid-portion of the nuclei is connected with the medial recti and has to do with convergence. The anterior portion of the nuclear column is supplied by the posterior cerebral and the posterior portion by the basilar artery.

From the third nerve nucleus, the fibers run forward through the posterior longitudinal bundle, the tegmentum, the red nucleus, and the substantia nigia to emerge from the surface of the brain in the oculomotor groove, on the medial side of the cerebral peduncle. It then passes around the peduncle going from the medial to the lateral side between the posterior cerebral and superior cerebellar arteries, to perforate the dura at the level of the posterior clinoid process where it lies medial to the rostral portion of the temporal lobe. After piercing the dura, it comes to lie in the paratrigeminal fossa, in close relation to the internal carotid artery and the gasserian ganglion of the fifth nerve.

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The nerve then travels forward in the lateral wall of the cavernous sinus where it lies in close relationship with the internal carotid artery and the fourth, fifth and sixth nerves. It then enters the orbit through the superior orbital fissure, thereafter dividing into a superior and inferior division. The superior division supplies the levator palpebrae superior and the superior rectus, while the inferior division sends branches to the medial and inferior recti and the inferior oblique muscles. That branch of the inferior division supplying the inferior oblique muscle also gives off the preganglionic motor root to the ciliary ganglion.

Variations in the nerve, for the most part, consist of unusual branches which at times seemingly replace one of the other orbital nerves. Thus, the third nerve may give off a branch to the external rectus in addition to or in exclusion of it or may give off a filament to the superior oblique muscle. Minor deviations in the course of the third nerve have been recorded.

SITE OF LESION

Lesions of the oculomotor nerve may occur at any one of the following locations in the course of the nerve:

I. Nuclear
II. Intra-medullary
  a. at level of red nucleus
  b. at level of pyramidal tract
III. Inter-penduncular fossa
IV. Between posterior cerebral and superior cerebellar arteries
V. Beneath temporal lobe
VI. Para-trigeminal fossa
VII. Cavernous sinus
VIII. Superior orbital fissure
IX. Apex of orbit

External oculomotor nerve ophthalmoplegia is characterized by involvement of all of the extra-ocular muscles (levator of lid; the superior, inferior and medial recti; and inferior ob-

lique). The internal (pupillary) ocular musculature is spared. A patient with external ophthalmoplegia displays ptosis and when the lid is elevated, the eye is divergent and the globe cannot be elevated, depressed, or adducted.

Internal oculomotor ophthalmoplegia indicates involvement of the internal (pupillary) ocular musculature, with no involvement of the extra-ocular muscles supplied by the third nerve (elevator of lid; inferior oblique; and superior, inferior, and medial recti). These patients demonstrate only a dilated pupil that reacts neither to light nor to accommodation, but the affected eye can be moved in all directions.

A complete oculomotor nerve opthalmoplegia is a combination of external and internal ophthalmoplegia. These patients demonstrate ptosis and when the lid is elevated the affected eye is divergent, the pupil is dilated and reacts neither to light nor accommodation, and the affected eye cannot be elevated, depressed, or adducted.

NUCLEAR LESIONS

Nuclear lesions may be of vascular origin such as in hypertension, arteriosclerosis, diabetes, blood dyserasias, and traumatic hemorrhages; of inflammatory origin such as in encephalitis, poliomyelitis, meningitis, tetanus, diphtheria, and botulism; degenerative; toxic; or neoplastic such as glioma of the midbrain. Congenital nuclear aplasias, either partial or total, unilateral or bilateral, are also known to occur.

Nuclear lesions are characterized by their bilaterality and irregularity and the presence of diplopia. They are capable of affecting all the extra-ocular muscles without producing internal ophthalmoplegia (dilated pupil), whereas peripheral lesions always produce some degree of internal ophthalmoplegia as well.

Nuclear lesions due to trauma usually are the result of petechial hemorrhages due to obstruction of blood flow in the vena nervosum. Later, small foci of necrosis may develop in the floor of the fourth ventricle or deeper in the pons. Sometimes, after ophthalmoplegia has cleared, fatal apoplectic hemorrhage from such a focus can occur.

The etiology of congenital aplasia of the oculomotor is not known but the tendency for it to appear in several members of a family indicates that defects of development or intrauterine degenerative processes play the largest role. These congenital ophthalmoplegias are present at birth, may be unilateral or bilateral, and often are associated with other malformations and peculiarities of development. These lesions show a tendency to remain stationary throughout life.

The most common example of an oculomotor nerve defect is congenital ptosis. In most instances, the remaining oculomotor muscles are not affected, although in some cases, the superior rectus is defective. Complete paralysis of all the muscles innervated by the third nerve on one or both sides may be present from birth. Bradburn has reported three cases of congenital aplasia of the third nerve nucleus which occurred in five generations of a single family.

Paralysis of the third nerve has been found in association with anomalous development of the right subclavian artery, which in these cases arises from the thoracic aorta and courses behind the esophagus, causing compression and dysphagia.

OCULOMOTOR NEURITIS

Once the third nerve has emerged from the nucleus, it may be involved by a neuritic process at any point, from the nucleus to the apex of the orbit, by such conditions as produce polyneuritis including alcohol, lead, arsenic, carbon monoxide, diabetes, herpes zoster, and vitamin B deficiency.

INTRA-MEDULLARY LESIONS

Lesions of the third nerve occurring in the substance of the midbrain usually are of vascular origin, although brain stem neoplasms, multiple sclerosis, and tabes dorsalis also have been implicated at various times. A lesion at this level is characterized by involvement of all the external ocular muscles (superior, inferior, medial interior rectus, and inferior oblique) excepting the lateral rectus and superior oblique, plus involvement of the pupillomotor fibers giving the picture of an ipsilateral ptosis; when the lid is elevated, the eye is found to be abducted and the pupil dilated and fixed. The patient is unable to elevate, depress, or adduct the affected globe. In addition lesions in the area are characterized by the involvement of adjacent structures in the brain stem, either the red nucleus or the pyramidal tract.

Involvement of the red nucleus gives rise to the syndrome of Benedick, characterized by an ipsilateral oculomotor nerve ophthalmoplegia

with a contra-lateral hemi-tremor. If the lateral lemniscus also is affected, there may be a contralateral hemi-anesthesia.

Involvement of the pyramidal tract gives rise to the syndrome of Weber, which is characterized by an ipsilateral oculomotor nerve ophthalmoplegia associated with a contralateral hemiplegia.

INTERPEDUNCULAR FOSSA

This lesion occurs at the point of exit of the oculomotor nerves from the substance of the midbrain. Lesions in this area result from involvement of the nerves by exudates and adhesions following tuberculous, lues, or purulent meningitis pooled in the recess formed by the peduncles. In this location, involvement of the nerves usually is bilateral and irregular with associated bilateral and irregular involvement of the pyramidal tracts and other cranial nerves, particularly the 5th, 6th, 7th and 8th.

Compression of the oculomotor nerve as it passes around the cerebral peduncle between the posterior cerebral and superior cerebellar artery is thought by some to cause involvement of the third nerve in the syndrome of ophthalmoplegise migraine.

TEMPORAL LOBE LESIONS

Involvement of the oculomotor nerve as it lies medial to the rostral portion of the temporal lobe is not uncommon and accounts for dilatation of the ipsilateral pupil in cases of subdural hematomas. Large tumors of the temporal lobe may press upon the nerve but more commonly herniation of the medial portion of the temporal lobe through the incisura of the tentorium, as a result of increased pressure in the supratentorial or intracranial cavity impinges upon the third nerve, giving rise to an ipsilateral dilated pupil and, in severe cases, to complete third nerve ophthalmoplegia.

PARATRIGEMINAL LESIONS

In this area, the oculomotor nerve is most frequently affected. Involvement is characteristic of sacular aneurysms of the internal carotid arteries. Sacular aneurysms of the internal carotid artery usually arise from the posterior wall of this vessel and project posteriorly, coming to rest in the paratrigeminal fossa containing the oculomotor nerve and the Gasserian ganglion of the trigeminal nerve. By coming to lie upon these structures, these aneurysms give rise to the paratrigeminal syndrome consisting of pain (trigeminal neuralgia) in or behind the eye, oculomotor nerve ophthalmoplegia, and diminished or absent corneal sensation due to involvement of theophthalmic division of the trigeminal nerve. In approximately 15% of all cases, characteristic curved-linear suprasellar calcifications may be seen on radiographic examination of the skull. Arteriography usually establishes the diagnosis.

In this location, a similar picture as that just described may be produced by tumor of the Gasserian ganglion, metastatic carcinoma to the region of the Gasserian ganglion, nasopharyngeal carcinoma that has eroded the base of the skull into this area, and meningioma of the petrous portion of the temporal bone.

Tumors of the Gasserian ganglion can be ruled out only by exploratory craniotomy. Metastatic carcinomas usually produce radiographic evidence of destruction of the base of the skull, while petrous ridge meningiomas usually give rise to X-ray changes in the petrous portion of the temporal bone. In nasopharyngeal carcinoma that has eroded into the base of the skull, oculomotor nerve palsy almost never exists alone. There usually is involvement of the 9th to the 12th cranial nerves.

CAVERNOUS SINUS LESIONS

Involvement of the oculomotor nerve in the cavernous sinus may be due to a cavernous sinus thrombus or it may be on an infectious basis; unruptured sacular aneurysm of the cavernous portion of the internal carotid artery; carotid artery cavernous sinus fistula resulting from a spontaneous or traumatic rupture of a normal or aneurysmal internal carotid; or primary or secondary tumors in the cavernous sinus.

In the cavernous sinus, the oculomotor nerve is in close relationship with the 4th to 6th and the ophthalmic and maxillary divisions of the trigeminal nerve. Because of this, in the case of aneurysms, as the aneurysm expands and fills the cavernous sinus, it compresses the third, fourth, sixth, and two divisions of the trigeminal. As a result, involvement of the third nerve in this position frequently is associated with a 4th, 5th and 6th nerve ophthalmoplegia as well. This gives the following picture of pain, in and around the ipsilateral orbit and an altered sensa-

tion in the region of distribution of the first of the two divisions of the trigeminal nerve. In addition, the ophthalmoplegia gives the patient ptosis and when the lid is elevated, the eye is in the straight forward rather than the divergent position, the pupil is dilated and fixed, and the patient is unable to elevate, depress, adduct, or abduct the affected globe. Arteriography usually establishes the correct diagnosis.

Involvement of the oculomotor nerve by a carotid artery-cavernous sinus fistula produces a somewhat similar picture plus the findings of a pulsating exophthalmos with edema and engorgement of lids and conjunctiva. Due to the communication of the cavernous sinuses by the anterior and posterior inter-cavernous sinuses, in this condition, the opposite oculomotor nerves may be involved as well.

SUPERIOR ORBITAL FISSURE

Involvement of the oculomotor nerve as it passes through the superior orbital fissure may be secondary to a suppurative process in the adjacent sinuses, fracture of the orbit or base of the skull extending into the fissure, or by the extension of a tumor from the paranasal sinuses.

Because of the association of the third nerve in the superior orbital fissure with the 4th, 6th and ophthalmic and maxillary divisions of the 5th nerve, occulomotor nerve ophthalmoplegia in this area frequently shows involvement of these nerves as well. In this region, due to involvement of the sympathetic fibers to the pupil as well, the pupil may be relatively miotic and fixed rather than dilated and fixed. History of trauma or sinusitis plus X-ray examination of the base of the skull, orbits and sinuses, will establish the proper diagnosis.

APICAL ORBITAL SYNDROME

The oculomotor nerve may be involved in the apex of the orbit by traumatic hemorrhage or orbital abscess or tumor. The apical orbital syndrome is characterized by oculomotor ophthalmoplegia, either complete or internal or external, plus a variable degree of exophthalmos, and edema or atrophy of the optic nerve head. History, plus X-rays of the optic foramen and orbit help resolve the diagnosis.

DIFFERENTIAL DIAGNOSIS

Oculomotor nerve ophthalmoplegia must be differentiated from myasthenia gravis and chronic progressive ophthalmoplegia externa.

Myasthenia gravis, which is characterized by excessive fatigability of striated muscle is due to a deficient transmission of the nerve impulses to the muscle fiber. In its commonest form the patient has diplopia and ptosis, usually bilateral. Involvement of the remaining extraocular muscles follows no definite rule and while extraocular muscle palsies are fleeting at first, as the disease progresses, external ophthalmoplegia becomes complete and permanent. The ocular muscle paralyses are most marked in the evening or after excessive or fatiguing tasks. Diagnosis may be made by the history of diurnal variation of ptosis, production or augmentation of ptosis by fatiguing the levator, and the dramatic relief of ptosis following the injection of 1-2 c.c. of prostigmine.

Chronic progressive ophthalmoplegia externa, produces bilateral progressive ophthalmoplegia with sparing of the intraocular musculature. Whether this condition is primarily ocular muscle abiotrophy or a nuclear degeneration remains unanswered. The condition, which is heredofamiliae, appears usually in early life and is progressive but offers no danger to life. Ptosis without diplopia is one of the earliest manifestations of this condition, and as the condition progresses the extraocular muscles of both eyes become involved with sparing of the pupillary muscles. There is no diurnal variation of ptosis and the injection of prostigmine is ineffectual.

SUMMARY

The anatomy and course of the oculomotor nerve are reviewed. The site of lesions of this nerve and their diagnostic features are presented. Differential diagnosis from myasthenia gravis and chronic progressive ophthalmoplegia externa is discusssed.

"Old Doc," First Auto Test Driver

JOHN A. MIRT, CHICAGO

WHEN in 1901, the late Dr. Charles H. Mayo, noted surgeon of Rochester, Minn., in a letter to the editor of The Journal of the American Medical Association reviewed the relative merits of three types of a new-fangled "horseless carriage" he set off a chain reaction.

Dr. Mayo, who along with his brother, the late Dr. William J. Mayo, had founded the Mayo Clinic, was then the owner of a "steam buggy." He had operated gasoline-driven and electrically propelled machines as well. In his letter, he reported the advantages and disadvantages of each type, in answer to a previous request from a "Dr. H. S. J." in Lead, S.D.

The mechanical keenness of Dr. Mayo equalled his surgical skill for he concluded: "Steam is the most sure power, yet the rapid advancement of gasoline engines will undoubtedly make them the most convenient in another year."

The letter elicited great interest in the new "contraption" among his medical colleagues. In the seven years to follow, the family doctor collectively was to become the test driver for the automobile industry, then in its infancy and subject to growing pains and the ills of improper nutrition. "Old Doc" was to report his "clinical" and "autopsy" findings in mechanical and scientific detail for the benefit of future motor car engineering and construction.

The Indianapolis Motor Speedway as a test of stamina for engines and accessories was not to come upon the scene until 1911. There were no proving grounds in those early days. No group was in a better position than the 100,000 physicians of the nation to give the automobile its needed, thorough workout, and to find its mechanical defects.

To them, rapidity and certainty of transportation were material and practical considerations. The long time spent in travel was an economic waste. In some instances, the speed with which a physician reached his patient was a factor between life and death. So, he took up the new automobile not for pleasure but for professional—and competitive—reasons.

Manufacturers realized that there could be no greater testimonial for their products than to have the family doctor make his calls in city and country by auto. Promotion was directed at the medical profession. Physicians gradually switched from horses.

"Doc" guided his automobile over city and country, on good roads and bad, through mud, snow, sand and clay, up hill and down, day and night, winter and summer under every weather and road condition imaginable. He went out when other car owners dared not.

When the mechanical "bugs" of his machine showed up—and this happened much too frequently—he had no one to turn to for help. Repair shops were few and far between. Moreover, mechanics were of little help because of lack of standardization of parts and designs. Each model of car required a particular knowledge of its workings. So, he had to "get out and get under." With the aid of a few choice, non-medical words, he did the repairing himself.

It became evident that medical and mechanical emergencies were Siamese twins. In order to deal with both, the physician learned the mechanics of an automobile the hard way. He pored over technical books dealing with the principles of gasoline and steam engines, electric motors, fuels, storage batteries and other accessories. He tinkered with a car in a stall in an old stable. In time, he came to know the anatomy of his automobile as well as that of his patients.

The Journal carried spasmodic and individual reports from physicians on their experiences with the new form of transportation. By 1906, the automobile was recognized as an important potential factor in better medical care. Yet, manufacturers were not far along the way to solving their mechanical problems.

On March 24 of that year, the Journal editorially took cognizance of the uncertainty which

existed. It had compiled a large number of experience reports, but wanted more.

"To no one class of people is the automobile of more practical importance as a business proposition than to physicians," the medical publication said. "Whether in the city or country, the physician needs a means of quickly, safely and surely reaching his patients—and of getting home again."

It asked for reports on both sides of the subject—"experiences and difficulties connected with the machine as compared with the horse, the type of car most practical, technical points connected with gears, transmissions, cylinders, fuel, cooling apparatus, tires, etc."

On April 21, 1906, 36 pages were devoted to the driving experiences and suggestions of 68 physicians. "Clinical" and "autopsy" findings were reported in great detail. "Treatments" were prescribed. Advice was given on how to avoid "symptoms" of a disorder. "Systemic weaknesses" were revealed, pointing the way to future engineering designing. The pros and cons of every type of power, transmission, electrical system, cooling method, wheel and tire were presented. Each accessory had its proponents, who gave sound mechanical reasons for their opinions. The argument was heated.

Typical of the detail in specifications was the recommendation of Dr. C. E. Rogers, Montevideo, Minn. Based on ownership of three cars and travel twice the distance around the world, he said: "The engine should be multiple cylinders; gasoline is best and cheapest fuel; sliding gear transmission; drive of the shaft pattern; cooling system, water: half elliptical springs; double tube tires; storage battery for spark and ignition; acetylene lamps."

Solid tires worked best on mud roads, according to Dr. Eugene F. Talbott, Grinnell, Iowa. The pneumatic tire was "too wide to go into the rut made by wagon wheels."

He had many supporters because pneumatic tires in those days were in disfavor despite their easier riding qualities. Flat tires were too common occurrences to suit physicians on a hurry call.

Only on one point was there agreement. The physician had to be an auto mechanic as well as a medical man.

A purchase should not be made unless the physician also undergoes training in gas engineering, Dr. C. P. Thomas, Spokane, wrote. He added: "He should know the mechanics of his car as well as he knows his surgical instruments." He advised his colleagues to "get on the band wagon" because the automobile was here to stay.

"Study and understand your car as you do the human body," Dr. Rolandus G. Walker, Denver, recommended. "Learn to diagnose your trouble when it arises. Understand the physiology of your engine. Apply the treatment as when you prescribe drugs in your daily practice."

When Dr. F. J. Bomberger, Mapleton, Minn., had trouble on the road and was asked: "What's bothering you, Doc?" his reply was: "My deplorable ignorance." Then he took up a study of gasoline engines and his troubles ceased.

From Dr. William Thompson, Chicago, came the sage advice concerning autos: "Study its anatomy and physiology, and all the pathology that you can acquire."

Dr. Harry S. Kiskadden, Detroit, urged physicians to be able to tell the "pulse and respiration" of their cars. The automobile of Dr. W. P. Hartford, Cassville, Wis., was subject to "attacks of indigestion" and sometimes was suspected of "malingering."

Although the "three-wheeler" purchased in 1901 by Dr. H. C. Martin, Springfield, Mass., "coughed and coughed" for six years, it was good for 50,000 miles. The secret: He spent 30 to 45 minutes each morning checking "the whole wagon."

Irked by jibes when a breakdown occurred, Dr. Charles Moir, Louisville, donned overalls and "made a thorough dissection of his machine." He reported: "Result: No more street scenes, as I can get started before the crowd gets around. As for a vocabulary of interjaculatory speech, I do not need it rewritten, and I am now going to teach a Sunday school."

Dr. F. M. Crain, Redfield, S.D., was prophetic when he wrote: "One of the beneficial results of the use of the automobile will be its effect on the good roads movement."

In contributing to the symposium on comparative cost of automobile and horse, Dr. Charles P. Sylvester, Dorchester, Mass., gave a report which would do credit to a certified public accountant. Expenses listed included a $5.25 item for "loss of eyeglass while raising a 30-mile breeze in the woods" and 10 cents carfare

when his automobile had to be left behind after a breakdown. Charges against horse upkeep included eight cents for sugar and 50 cents for gin—not explained. The automobile came out $110.45 cheaper over seven months.

He was analytical in other respects. He kept tab of his pulse beats and found the tension of long drives increased his rate by six beats per minute. "The public's probably went higher," he added.

Dr. C. B. Miller, Helena, Mont., was a skeptic on his first trip to see a patient six miles out in the country. He had his horse and buggy follow him. The caution paid off. On the way back, he experienced carburetor trouble. Eventually, he mastered the intricacies of the vehicle and became a booster.

"The traumatism of the conjunctiva in motoring is very severe and one should always wear goggles," Dr. Joseph A. Robertson, New York, advised. He discussed in mechanical detail the relative merits of various types of accessories.

But not all reports were favorable to the new industry. A sad experience was related by Dr. Sterling Gibson, Thomson, Ga. He thought by buying an automobile he could dispose of one of his two horses. But he reported: "I found I would have to get a third horse."

Experience with an 8-h.p., one cylinder, water-cooled gasoline runabout in country practice for two seasons caused Dr. F. A. Swezey, Wakonda, S.D., to report: "I will never buy another."

Subsequent letters to the editor showed that physicians all over the country appreciated this special feature. One point made was that the experiences would awaken manufacturers to the problems of motoring, especially in cases where certainty of performance under adverse conditions was of paramount importance.

From Dr. J. D. Southard, Fort Smith, Ark., came the prediction: "This edition of The Journal will increase the sale of automobiles more than anything that has ever happened."

Producers apparently were of the same mind because several were represented at a commercial exhibit alongside surgical supplies, pharmaceuticals and other doctors' needs at the annual meeting of the American Medical Association in Boston in June, 1906. They experienced an unusual professional interest in "motor cars adapted to the physicians' use."

By the fall of 1907, physicians from all parts of the country were asking for more information. The Journal called for reports on one, two and four-cylinder machines both as to efficiency and cost of operations.

It wanted to know the comparative value of large and small cars; the relative usefulness of the automobile on various kinds of roads—loam, clay, sand, etc., hilly and level; the methods used to prevent skidding; the relative merits of air-cooled and water-cooled cars; the anti-freezing material used; the preference, whether for electric, steam or gasoline automobiles, and why.

"Experiences, not theories are wanted," The Journal emphasized.

On March 7, 1908, in a number which carried articles on "Subphrenic Abscesses as a Condition of Appendicitis," and "Exophthalmic Goiter," 27 pages were devoted to "The Physician's Automobile." More than 100 reports were contributed by physicians.

Illustrations showed physicians' cars sloshing through water holes on country roads, pushing through snow drifts or bumping over rock-littered roads; cars with tops up, tops rolled back, no tops; drivers in dusters, caps and goggles; machines with high wheels or low wheels; cars with pneumatic tires or solid tires.

Usually, the physician was pictured at the wheel. One illustration showed him in the back seat while his wife and daughter sat up front.

Operating expenses were reported in great detail. Physicians gave the relative costs of keeping a "hay burner" and a "gasoline burner." Which mode of transportation the figures favored depended largely on repair expenses.

Some physicians found it cheaper to operate an automobile, but few took into consideration the matter of depreciation. Others said horse and buggy were less expensive, but many added that the time saved more than offset the added cost of a car.

By then, the preference trend had been established. Trials under all conditions had brought out the better advantages of gasoline engines, pneumatic tires, multi-cylinder motors, drive shaft transmission, sliding clutch, water cooling systems and low wheels. These were reported in

mechanical detail and these were to become the specifications for the "physician's car."

The consensus was that the physician should own an automobile, but more than half of the physicians still emphasized that knowledge of mechanics was a requisite to satisfactory operation.

So widespread was the demand of physicians for mechanical knowledge that among books advertised in The Journal was J. E. Homans' "Self-Propelled Vehicles." Described as a "thorough course in the science of automobiles," it contained more than 400 illustrations and diagrams.

Nevertheless, the horse and buggy remained "an ace in the hole" for many physicians. Dr. E. T. Fields, Ensley, Ala., kept a team in reserve. In Lubbock, Tex., Dr. M. C. Overton depended on hired horses for use in muddy weather.

Memphis in those days had many unpaved streets. Dr. Max Henning of that city advised his confreres not to buy an automobile unless a horse and buggy were kept for use on bad streets.

Summarizing the opinions of physicians, The Journal said: "The automobile, while far from perfect, has reached that stage where it is a practical and economical conveyance under certain conditions. To the physician who has some mechanical genius, it is not only a welcome substitute for the horse, but it is a valuable means of recreation and diversion."

It made recommendations which the automobile industry adopted: Standardization of parts to cut production and maintenance cost; a $500 car, which Henry Ford eventually produced; reliability of performance; simplicity of construction to make parts easy to reach.

The editor decried the craze for speed and called for a 20-mile-per-hour-limit. He urged physical qualifications for drivers, pointing out that "if an automobilist is out of health, nervously weak, defective in sight and hearing, or under the influence of drugs or stimulants, he is not a safe man to run an automobile."

Physicians occasionally used their automobiles for other than transportation purposes. Dr. A. R. Baker, Cleveland, connected the battery in his electric car to an electro-magnet in his office. The power delivered excelled street current for magnetic removal of steel and iron from the interior of the eye in more than 30 cases, he informed his colleagues.

In Rome, N.Y., Dr. W. B. Reid found that the lighting in country houses frequently was insufficient for emergency surgery. He backed his automobile to a window, passed the acetylene lamp into the house and connected it with the gas tank on his automobile by means of a rubber tubing.

"The light is as good as in any well-appointed operating room," he reported.

Dr. J. H. Guinn, Arkansas City, Ark., ran wires from his garage to his office, connecting the battery in his electric automobile to electrotherapeutic apparatus. He eliminated "the annoyance and expense in keeping up a galvanic apparatus," he wrote.

At the American Medical Association's annual meeting in Chicago in June, 1908, five automobile makers displayed their products. Buick and Cadillac had special "physicians' cars." Bendix Company, Chicago, had a four-cylinder, high-wheel model. Doctors were invited to tour the Bendix plant to see cars in construction.

Holsman Automobile Company and J. V. Lindsley & Co., Chicago, had displays.

For the physician who still was not sold on the automobile, or who wanted a backstop, Heinzelman Brothers Carriage Co., Belleville, Ill., exhibited two of its popular style buggies.

On March 6, 1909, a third automobile section was published. It comprised 34 pages. Automotive engineers contributed articles as well as physicians. There were symposiums on wheels—low and high; on tires—solid and pneumatic; on motors and transmissions; on lubrication.

Dr. J. E. Alleben, Rockford, Ill., likened the advance in the automobile industry to that in surgery—"after many years of patient labor and experiment."

From then on, the automobile industry grew fast. In 1911, the Indianapolis Motor Speedway staged its first 500-mile race, to put the automobile to a grueling test. This merely added speed to the earlier trials.

But the physicians of the country had served as the first test drivers under actual road conditions.

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CASE REPORTS



Juxtadiaphragmatic Rupture of the Esophagus

KORNEL J. FOJCIK, M.D., CHICAGO

RUPTURE of the esophagus near the diaphragm was described as early as 1724 by the ingenious Dutchman, Boerhaave.[4] But this pathological entity does not yet have its permanent name. Most of the authors use the name spontaneous rupture of the esophagus.[1,2,5,7,8] Samson[12] proposed the name postmetic rupture, Moynihan,[11] pressure rupture, and Wangensteen,[15] acid peptic perforation of the esophagus. According to Chamberlain and Byerly,[6] experimentally and mechanically so-called spontaneous rupture of the esophagus does not occur unless by some extraesophageal force that suddenly increases the intraluminal pressure. As it is an organ rupture, it should be considered traumatic in origin.

All the above nomenclature embodies worthwhile ideas, but no one of these terms is ideal; therefore I will place all in one category and use the term, juxtadiaphragmatic rupture of the esophagus because this rupture, in spite of different causes, is characterized particularly by its location near the diaphragm. Regardless of the name of this entity, early diagnosis and immediate appropriate therapy is needed.

Boerhaave[4] described this condition in these words: "The Illustrious Baron Wassenaer, Lord High Admiral of the Republick, after intense straining in vomiting, broke asunder the tube of the esophagus, near the diaphragm, so that after the most excruciating pains the aliments which he swallowed passed, together with the air, into the cavity of the thorax, and he expired in twenty-four hours."

The history, symptoms, and signs of juxtadiaphragmatic rupture of the esophagus are quite characteristic in spite of the fact that probably not more than 200 cases have been described. Most diagnostic failures are due to the fact that the examiner is unaware of the symptoms of rupture of the esophagus or simply fails to think of it.[1]

After a concise review of this problem I intend to present a case of juxtadiaphragmatic rupture of the esophagus in which diagnosis was made at autopsy.

The first antemortem diagnosis was made almost one hundred years ago by Schoenlein, and reported by Meyer.[10] According to Sandberg,[13] G. Petren collected 30 cases from the literature in 1926 and made a detailed study of symptomatology. The first successful repair of the rupture was reported in 1946 by Barret.[3]

In this article I am omitting the description of all research pertaining to experimentally caused ruptures on cadavers. According to Anderson,[1] 85 to 90 per cent of cases occur in men. In the study of Ware et al.[16] there were 68 males, 14 females, and four in which the sex was not mentioned. One of the factors is that the men are more addicted to alcoholism than are women. Juxtadiaphragmatic rupture of the esophagus

From the Swedish Covenant Hospital

may occur in infants and in the aged but most commonly occurs in middle-age. Some patients have a previous history of alcoholism, overeating, or gastric ulcer. Others have no known pathologic history.

Immediately following rupture, the patient is seized by sudden excruciating pain in the epigastrium or behind the sternum, sometimes radiating towards the shoulders, usually after vomiting or followed by vomiting. Pain rarely is relieved by a single injection of a narcotic. The rupture is followed by shock with low blood pressure, thready pulse, shallow, rapid, painful respiration, pallor, and cold sweats. Slight cyanosis follows.

In the carefully done large statistical study of Ware et al.,[16] epigastric pain, vomiting, and chest pain were the most frequent symptoms. These authors state also that hematemesis or thirst may be the presenting or initial symptom in a small number of cases but these symptoms do not assume the importance of pain or vomiting. Thirst as an early symptom is not as common as it has been quoted to be by early authors.

Initially there is subnormal temperature; later, rising fever. The upper abdomen usually is hard and tender; the lower, soft. If rupture is into the pleural cavity, hydropneumothorax is present, most often on the left side. Hoarseness may be present. Subcutaneous emphysema is not always an early physical finding, but has been a late development in some patients studied by Ware et al.[16] They state that in cases in which rupture occurs directly into the pleural cavity rather than first into mediastinum, subcutaneous emphysema may be completely absent. In the material of Anderson[1] emphysema was present in 88 per cent of cases. According to Eliason and Welty[8] "some have been able to detect an abnormal sound of fluid and air in auscultation of the chest during the swallowing of water." Gardner[9] made his tentative diagnosis by observing the rapid respiration, crepitus of the neck, and rigidity of the abdomen. It is, in my opinion, not advisable to pay too much attention to different triads of symptoms and signs described by some authors. It is much more useful to know and observe the entire broad spectrum of symptoms and signs, and to know that such pathological entity exists.

The location of all those ruptures invariably is in the lowest part of the esophagus (juxtadiaphragmatic). Almost all are longitudinal and often in the left posterolateral wall of the esophagus. Several cases have been reported in which it is difficult to determine the exact pathology whether perforation or rupture.[7]

The differential diagnosis involves ruptured peptic ulcer, coronary thrombosis, spontaneous pneumothorax, broncho-pleural fistula, acute pancreatitis, ruptured gall bladder, dissecting aneurysm of the aorta, pulmonary embolism, incarcerated diaphragmatic hernia with or without rupture of stomach or bowel and splenic embolism.

If the possibility of juxtadiaphragmatic rupture of the esophagus is taken into consideration, differential diagnosis will not be too difficult and proper diagnosis may be made in large percentage of cases by history, physical examination, and observation of the patient. Immediate X-ray examination of chest and abdomen, electrocardiogram, serum amylase and history of gastroduodenal ulcer or gallbladder disease will be helpful in the differential diagnosis. Diagnosis will be easy if there is shallow, painful, and rapid respiration, mediastinal or subcutaneous emphysema, cyanosis, hydropneumothorax with shock and tenderness in the upper abdomen.

The passage of lipiodol or barium into the pleural cavity or into the mediastinum is a pathognomonic sign of the juxtadiaphragmatic rupture. Such findings as electrocardiogram characteristic for coronary thrombosis, pneumothorax not associated with shock, subdiaphragmatic air, high serum amylase will suggest other possible pathologic entities. According to Scannel[14] the clew of the diagnosis is the character of pain, which is similar to that of perforated ulcer in its onset and prostrating effect but with a substernal and pleuritic component.

The therapy of juxtadiaphragmatic rupture of the esophagus is surgical, and the method of choice is thoracotomy and repair of rupture, which should be performed as soon as possible. Gastric tube should be inserted. It is known that some patients in whom no closure of the rupture was performed, survived. In the last study of Anderson,[1] in 50 cases of different authors, only drainage was performed in nine. One of these patients survived. In 19, thoracotomy and closure of rupture was performed; 14 survived. Of

22 without surgical therapy, none survived. Castenfors[5] from Sweden reported a case in which diagnosis was not established until six months after onset. The patient was discharged as cured one year after drainage of a left pleural empyema.

Another Swedish author, Sandberg,[13] did not suture the rupture in a 49 year old man in spite of the fact that diagnosis was immediately made. Antibiotics generally and intrathoracally, oxygen, macrodex, and gastric tube were started immediately. Thoracocentesis was performed 16 hours after the onset. A solution of methylene blue taken by mouth ran out through the chest drainage. Roentgenography performed three weeks later did not show any rupture and two days later the gastric tube was removed. The further course was excellent. The lung was re-expanded by having the patient inflate a rubber balloon.

Prognostically, the outcome is extremely guarded, but it has improved in recent years with prompt surgical intervention and antibiotic coverage.[6]

Case history:* The patient, a 64 year old retired pharmacist, had been a heavy drinker in the past but not recently. He had had dyspnea on mild exertion for several years. He lived alone. According to his son, the patient had complained intermittently of indigestion for the past week. He was in bed and was seen with a hot water bottle on his abdomen at one time. Being a pharmacist, he probably treated himself during this period. The day before admission he seemed older to his daughter-in-law.

On the day of admission he suddenly developed severe chest pain with pallor, coldness, clamminess of the skin, and extreme dyspnea. A registered nurse was called to care for the patient; she believed he had a coronary occlusion and gave him 100 mg. demerol hypodermically.

At admission 8:35 p.m. the patient complained of severe pain in the epigastric region and in the chest. He stated that he felt like coughing but could not. The face was ashen gray. The pulse was thready, 126/ min. B.P.: 68/26. Temp.: 101 Resp.: 24/min.

The patient was given ¼ gr. Morphine Sulfate and oxygen by nasal catheter. Because of the critical condition a chest X-ray and electrocardiogram was not done. Coronary thrombosis was suspected.

R.B.C.: 57% packed cells
Hb.: 15.4 Gm.
Urine was not obtained
W.B.C.: 8800
Kahn: Neg.

The B.P. soon became unobtainable. The patient went into severe shock and became unconscious. Some hours later the pulse rate was 116/ min. B.P.: unobtainable, temp.: 102 F., resp.: 30/min.* Moist rales were heard over the entire chest. The heart was not enlarged to percussion; there were no murmurs. The abdomen was soft and somewhat distended. The skin was cold and clammy with peripheral cyanosis. The patient was still moaning and had periods of apnea. The patient remained in shock, his course was steadily downhill, and he expired 16 hours after admission.

Autopsy: On opening the chest cavity there was a sweetish-sour smell resembling vomitus. The left pleural cavity contained about one liter of brown opaque fluid and the right cavity about one half liter. The lungs were crepitant. The mediastinum and the outer surface of the pericardium were fiery red. The lower part of the esophagus and the thoracic side of the diaphragm were brownish and superficially necrotic. On the left postero-lateral wall of the esophagus, four cm. above the diaphragm, there was a longitudinal rupture, one cm. in length. The pericardial sac contained thirty cc. of yellow fluid. The lower internal wall of the pericardium was fiery red. The heart weighed 360 gr. The wall of the left ventricle measured 19 mm. The myocardium was firm. The leaflets were smooth and pliable. The coronary arteries were wide and soft and they showed occasional yellow plaques. Microscopic: The esophagus showed absence of the squamous epithelial border. The cardiac muscle was well defined. Fatty changes were noted in the liver.

SUMMARY

This was a case of juxtadiaphragmatic rupture of the esophagus in the typical place: left posterolateral wall of the lower esophagus. The

*I express my thanks to Dr. A. C. Peterson for this case.

diagnosis was made at the autopsy.

As is sometimes the case, indigestion of one week's duration was present prior to the onset of acute symptoms.

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Psoriasis and diabetes

Whatever the metabolic disturbance may be which manifests itself in abnormal histochemical findings in the skin or blood of the psoriatic, we should not give it the label of a constitutional disease and dispense with further search for the real etiology. The history of diabetes should be a guide to teach us patience and caution against drawing premature conclusions. It is a long way from the discovery of the islands of Langerhans, insulin, and successful therapy of diabetes to the discoveries of the Cori cycle and ester and of the complexities of the interaction of pancreas, pituitary, and liver function. Modern research in psoriasis has not been amiss in looking for the organic disturbance which could be made responsible for the actual disease. The thyroid gland, the adrenals, the anterior pituitary, the pancreas, and the diencephalon have been given consideration, but the practical results have not been sufficient to be convincing. The importance of a factor X as the key to the problem of psoriasis was demonstrated to me by three chance observations made during a period of 35 years of dermatologic practice. It consisted of the dramatic disappearance of widespread and resistant psoriasis at the time these patients developed Graves' disease. This is in contrast with the lack of therapeutic results with thyroid extract or thyroxin and raises the question of the role of the anterior pituitary as the postulated factor X. *Paul Gross, M.D. Psoriasis. New York J. Med. Aug.* 15, 1957.

Coma
After Glutethimide (Doriden) Overdose

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ALTHOUGH most sedative and hypnotic needs encountered by the physician can be met by the barbiturate or chloral compounds, they have certain shortcomings which have led to a continued search for better substances. Among the drawbacks of the older drugs are 1. True addiction to the barbiturates with physical dependence and withdrawal symptoms, 2. Alleged partial tolerance with prolonged barbiturate usage and 3. "Excitement" produced in some very young or very old patients with barbiturates.[1]

During investigation of several compounds with anticonvulsant properties, it was discovered that a nonbarbiturate, glutethimide (Doriden®) depressed the central and autonomic nervous systems.[2] This led to further study of the compound and its eventual use as a sedative and hypnotic. Chemically it is alpha-ethyl-alpha-phenyl glutarimide.

The drug is readily absorbed and in a dose of 0.5 gram usually produces sleep in 20 minutes. The duration of action with this dose is 4-8 hours. Gastrointestinal irritation is minimal, although an occasional patient has anorexia, nausea, and vomiting. Occasionally dizziness or lightheadedness has been observed.[3] Other side effects reported[2,3,4,5,6,7] include rash, xerostomia, ataxia, excitement, confusion, and thick speech. In one patient, idiopathic jaundice developed concurrent with therapy and cleared spontaneously within eight days of cessation of treatment.[2]

Lane[4] found no abnormalities in the blood count, urinalyses, or thymol turbidity or cephalin flocculation tests in 37 patients treated with up to 1 gram daily. Forbes[8] reported minimal effect of glutethimide on psychomotor performance. When alcohol was administered with the drug psychomotor performance was substantially reduced.

Several cases of acute glutethimide intoxication have been reported. In one[9] the picture was that of deep coma for 23 hours, hypotension requiring Neo-Synephrine, and varying neurological signs after ingestion of 10 grams in a suicidal attempt. Another report[10] states that coma was present for 36 hours after a dose of 5 grams of glutethimide. One patient died in what was apparently a hypotensive episode after ingesting 20 grams of glutethimide.[9]

We wish to report a case of coma following ingestion of glutethimide:

A 21 year old white female was brought to the emergency room by her husband. The following information was obtained from him. On the preceding day, the patient complained of headache but otherwise appeared to be her usual self. Headaches was attributed to drinking too much alcohol the night before. On the morning of the day of admission when the husband left for work, she was still asleep in bed. He returned at 7:00 p.m. and found her unconscious on the bed and a bottle nearby containing two white pills. These were subsequently identified as glutethimide. The husband recalled that these pills had been given to him as a prescription for headaches. He did not believe that his wife had been depressed or ill in any way.

On admission the patient was completely unresponsive to verbal or painful stimuli. Numerous ecchymotic areas and abrasions were seen on the trunk and extremities. No signs of head injury were noted. Blood pressure was 130/78 on arrival but shortly thereafter it dropped to 100/60. The pulse was 100 on admission. Respirations were 24/minute and of good amplitude. The pupils were dilated and unresponsive to light but were symmetrical and equal. Fundoscopic examination was normal. Neurologic examination showed absent deep tendon reflexes

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in the upper extremities and equivocal knee and ankle jerks. No pathologic reflexes were elicited. No other abnormalities were noted.

A lumbar puncture revealed clear, colorless, fluid under pressure of 180 mm. of water. No cells were seen on microscopic examination. The urine gave negative reactions for sugar and acetone. A blood sugar of 220 mgm. per cent was obtained while glucose was being given intravenously.

Initial treatment consisted of maintenance of an adequate airway, administration of intravenous fluids, and gastric lavage. Four hours after admission the patient was given beta-methyl-ethyl glutarimide (Megimide)® in a dose of 50 mg. This was repeated 90 minutes later with no response. Fifteen minutes after the last dose of Megimide she was given intravenously 6 mg. of Amiphenazol.® Repeated doses of 9 and 16 mg. of the latter drug at 5 minute intervals produced no change in her condition. The patient remained unresponsive with slight temperature elevation to about 101 degrees rectally with a rise to 102.6° on the following day. Her blood pressure during the period of coma ranged between 100 and 130 systolic over 60 to 100 diastolic. The pulse varied between 120 and 140, while respirations were 28 to 40.

The first change, 36 hours after admission, was the appearance of a positive gag reflex and movements in response to painful stimuli, followed several hours later by nonpurposeful movements of the extremities. Improvement was progressive until 48 hours after admission to the hospital, the patient was completely awake, although she had prolonged hallucinatory episodes for the following 24 hours. These consisted of the fear that someone was trying to kill her, resulting in the refusal of foods and liquids, visualizing large snakes in the room, and seeing little men on the ceiling. Subsequently she was well oriented and recollected her hallucinations clearly. She was reluctant to talk about incidents leading up to her ingestion of the glutethimide. She did reveal that she made an abortive attempt at suicide in 1953 by swallowing an excess amount of Anacin.® The patient was discharged after six days of hospitalization to be followed as an outpatient in the psychiatric clinic.

COMMENT

It was concluded that the coma was induced by the ingestion of approximately 17 grams of glutethimide. The patient showed only minimal hypotension and respiratory depression. Megimide and Amiphenazole, 2-4 diamino 5 phenythiazole, were used because of recent reports[11,12] on their effectiveness in treatment of barbiturate poisoning. The former drug has some structural similarity to both glutethimide and the barbiturates and is thought to be a direct antagonist to the barbiturates. Amiphenazole is used as a synergist and respiratory stimulant. Rowell has treated glutethimide poisoning with these drugs and recommends their use in such cases.[13]

Although the newer hypnotics have been shown to be safe compounds when used legitimately, some persons will ingest large amounts for the psychic reaction obtained or in an attempt to commit suicide. Lasagna[1] emphasizes "one of the dangers accruing from the introduction of new hypnotics" is the implication of much of the advertising for, and thinking about, these compounds has been that the drugs are nonbarbiturate and devoid of danger. Attempted suicide has been reported with most of the new nonbarbiturates and serves to remind the physician of the importance of assessing the emotional status of his patient before prescribing large quantities of any drug. Unfortunately many nonprescription over the counter drugs remain available to the insomniac and emotionally disturbed individual.

SUMMARY

A case of coma following ingestion of approximately 17 grams of glutethimide (Doriden) is reported. The patient recovered after about 48 hours without after effects.

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The Finnish bath

The unique social institution of Finland is the sauna. This Finnish bath defies all thermal physiology yet is as commonplace as the bathtub in the American home. Some 80 per cent of all detached homes have a sauna as a detached building, usually on a lake edge. Nearly every residence, club, hospital, and most hotels have one or more saunas. Public saunas in which the sexes mix are here and there. The family sauna takes in the entire family at one time. There is something mystical or at least enigmatic about the sauna for most visitors, and it is something the native cannot or will not explain. Genuine eager interest in the sauna may lead to seemingly intelligent questions but even the best of friends may bristle a bit as though impertinent questions were being asked about the details of his sex life. At once the native goes on the defensive about the sauna, as though there was something shocking about it like addiction to marijuana. The inquiries might be, "Is this purely a social institution like the Englishman's tea? Is it a form of therapy? Is it merely a form of bathing for hygienic purposes? Is it a sport? Is it just a habit?" All such innocent questions may raise the hackles. At every book stall may be found popular books on the sauna. The contents do not answer all questions. Sometimes contradictions appear in different chapters of the same book. One chapter may advocate the sauna for hypertensive disease while another may condemn or recommend low temperatures.

Incompletely informed, it appears that the sauna is a dry, high temperature bath for prompting profuse perspiration, accompanied by birch bough flagellation to promote bettered circulation. Some hardbitten psychiatrists outrageously insist that the entire process is a ritualistic sex substitute. This is followed by a plunge into the lake, breaking the ice aforetime if necessary, or at the club, ducking under the cold shower at its coldest. The temperatures involved are amazing. Factually, the room temperature may exceed 212 degrees F. Temperatures as high as 260 degrees F., are mentioned without awe. The preferred temperature appears to be 190 degrees—still no highly chilled air. In America, we shudder apprehensively over the possible air conditioning shock and metabolic upset on passing from an artifical climate of 78 degrees F. into an outside summer temperature of 96 or just the opposite. Consider the Finn, either the hearty or near invalid one, who leaves his sauna temperature of 212 degrees F., in a trice plunges his well beaten skin into freezing water, coming up shouting with joy. Then he picks up his morning eggs, carried raw into the sauna with him, now well coagulated and ready for the breakfast table peeling. It's all perplexing. *The Editor in Scandinavia. Indust. Med. Sept.* 1957.

Homosexuality

A story of my clinical experience in Southern California some years ago will illustrate the complications involved in the evaluation of hormonal treatment. The medical literature at that time contained favorable reports of treatment of homosexuality by androgens, and it acquired a certain vogue. Several California jurists who knew the futility of sentencing homosexuals to jail began sentencing the convicted person to undergo treatment. Some were sentenced to hormonal treatment and others to psychiatric treatment. As a result of these efforts, further articles reported successful treatment with androgens—success that I, as a psychiatrist, envied.

One day a young man came to my office to consult me about a problem that only skirted on his homosexuality. A confirmed homosexual, he had little anxiety about his activities because he considered himself a constitutional homosexual and felt relatively blameless. In the exploratory course of our discussion, he said he had once been treated by androgens, not entirely of his own will, as the result of a court sentence. He then described how he and several of his associates had contrived to "respond" to the treatment, varying their stories so as to give them the hue of veracity.

He said that he arrived late for his first appointment and grumbled at the injection. The nurse reminded him to return for his next one or else. Next he complained of noticing no improvement at all. On the third visit he told the nurse he was depressed and said he and his boy friend had fallen out and might separate. Next time he was more depressed and was moving out, he said, because he could not tolerate his boy friend. The fifth time he carefully implied he was less depressed, and reported no difference except that he had no desire for anything or anybody. On the sixth visit he told the nurse, "A simply fantastic thing happened. I've been going to a local bookstore for years and never noticed before a very pretty girl who works there as a clerk." By the seventh visit he reported making a date with the girl and at the end of the treatment, claimed satisfactory sexual relations with her. This case figured in a published report of successful treatment. Meantime, this patient and his companions who had been treated also went on with their homosexual activities, except that some of them suffered from an increased drive—the result of the injections of androgens. How much of the exacerbation was biochemical and how much psychological, no one knows. Nor does anyone know to what extent similar ruses may have distorted medical results reported in the literature. *Normal Reider, M.D. Problems of Homosexuality. California Med. June* 1957.

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Hawaii, here we come

Plans for the two weeks' tour to Hawaii and return following the 1958 annual meeting of the AMA in San Francisco are jelling.

Members of the Illinois State Medical Society, their families and friends may take advantage of the specially arranged trip. Now is the time to fix the date for your 1958 vacation. Participants will leave San Francisco by plane, Thursday evening, June 26, arriving in Honolulu the following morning. Eight delightful days will be spent in the Islands.

The return trip of 4½ days will be made on the luxury liner, the S.S. Lurline, arriving in San Francisco, July 9.

Literature on what Hawaii has to offer in the way of entertainment may be had by writing to Mr. W. M. Moloney, c/o Harvey R. Mason Travel Co., Inc., Professional Building, Old Orchard, Skokie, Illinois.

EDITORIALS

Carrollton physician named Illinois "G.P." for 1958

Dr. Arthur Kirby Baldwin of Carrollton, Ill., was selected by the Illinois State Medical Society as "General Practitioner for 1958."

A plaque emblematical of the honor will be presented to Dr. Baldwin at the Society's annual meeting in Chicago in May.

The selection was made on the basis of his 37 years' record as a country physican, his service to the medical profession, his war record and his community activities.

Dr. Baldwin was born on a farm near Berwick, Warren County, Ill., July 12, 1888, the first of eight children of Mr. and Mrs. Charles L. Baldwin, who had a dairy farm. He was educated in country schools and Monmouth High School, where he was valedictorian of his class.

By that time, the youthful Baldwin had lost all desire for farming. He saw the medical needs of sparsely settled sections of the agricultural area of Western Illinois, and took a premedical course in the now defunct William and Vashti College at Aledo, Ill. This was followed by two years at the University of Iowa College of Medicine, Iowa City, and two years at the Rush Medical College, Chicago, from which he received his M.D. degree in 1916.

After interning for two years at Michael Reese Hospital in Chicago, Dr. Baldwin enlisted in the U.S. Army. He was in training at Camp Jackson, S.C., when the armistice was declared. He then volunteered for service in the American Occupational Force and moved as a first lieutenant with the army of occupation through Siberia in 1919 and 1920.

Upon his return to the United States, he took up the practice of medicine in Elmwood, Peoria County. Four years later he moved to Carrollton, where he has been in practice ever since.

Dr. Baldwin encountered the usual difficulties of a physician in a community without a hospital, but he met the challenge and provided medical care which won the approbation of his patients and his community.

In 1941, he, Dr. Arthur D. Wilson and Dr. Paul A. Dailey organized the 20-bed Thomas H. Boyd Memorial Hospital at Carrollton. This was doubled in size by an addition in 1950. Ten beds are being added by an obstetrical and gynecological unit now in construction.

Dr. Baldwin, who has served as president of the hospital's board of trustees since its inception, saw the need for modern anesthesiology and in 1949 he sacrificed a busy practice to take three courses over three years in that field at Cook County Hospital, Chicago, and refresher courses at the University of Kansas Medical School in 1955 and 1957.

He serves as anesthetist at nearly all operations at the hospital. To date he has adminis-



Arthur Kirby Baldwin, M.D.

tered anesthetic in more than 4,300 cases without an anesthetic death.

Dr. Baldwin's usual work day starts at 8 o'clock in the morning at his hospital. It ends about 10 o'clock at night in his office. He is subject to call at all hours.

With his busy medical practice, which takes him over a radius of about 15 miles, he still has found time to aid his community in other ways. He served as president of the School Board for three years, has been president of the Tuberculosis Sanatorium Board since its founding 10 years ago, and became charter president of the Lions Club in 1936.

He has served four times as president of the Greene County Medical Society and twice as delegate to the Illinois State Medical Society's House of Delegates. He also is a member of the American Medical Association, Illinois Society of Anesthesiologists and American Society of Anesthesiologists. He holds a National Board license to practice.

Dr. Baldwin married Miss Louise Murphy in 1922. They had first met while he was interning in Michael Reese Hospital where she was a nurse before she went overseas with Base Hospital Unit No. 14. They have three children, one of whom, James, is an orthodontist in Indianapolis.

Dr. Baldwin is a member of Carrollton Masonic Lodge No. 50, the First Presbyterian Church and the American Legion.

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Anticholesterol agents

Drugs that lower the cholesterol level are being announced by many pharmaceutical, chemical, and food concerns. The majority of these products contain vegetable oils and are prepared from corn, safflower, or soybean. Reducing the fat intake of the diet also lowers blood cholesterol and reducing weight has the same effect in the obese.

Many of these anticholesterol agents are high in calories and there is a possibility that the treatment may backfire if the result is a gain in weight. From 450 to 600 calories are consumed, for example, when corn oil is used according to directions.

There is considerable speculation whether these anticholesterol agents will become popular. The majority of patients want objective results from the medicines they take. Even if corn oil lowers blood cholesterol, many persons will discontinue the treatment after the third or fourth bottle since it has no effect on how they feel.

It is difficult to change human nature. The scare of lung cancer has not reduced the sale of cigarets and it is doubtful whether the scare of coronary thrombosis will make corn or safflower oil as popular as coffee on the dining room table.

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You can say that again

A patent medicine manufacturer who has changed the formula of his cold cure innumerable times without bothering to change the label finds himself unable to cash in on the present influenza vaccine bonanza. But there are other ways of making money in an epidemic than huckstering vaccine. Timed perfectly to save those citizens whose doctors are unable to secure vaccine, his laboratories have discovered a remarkable new citroid tablet "specifically designed to counter each important symptom of the common cold, adenovirus (APC) infections, and mild influenza." On our desk this morning is an

important looking envelope bearing this message: "When your patients start to ask about the new citroid. . . ."

When my patients ask ME about the new citroid, I shall tell them to take an aspirin and go to bed.

Editorial. Philadelphia Med. Sept. 27, 1957.

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Asian influenza spreading

Reports of a spreading of Asian influenza in a zigzag fashion throughout the country continued in recent months. The disease appears to have affected a large segment of the population and prospects were that millions of people will become victims of the virus.

Of considerable concern to the medical profession was the fact that many physicians were unable to obtain vaccine for their patients. At the same time, reports were current that some large industrial organizations, health departments, and other groups were able to obtain all they needed.

This situation placed many physicians in an uncomfortable position. The public was urged to be vaccinated, but when people tried to follow the suggestion they were told vaccine was not available.

AMA and the Public Health Service took cognizance of these reports and urged that manufacturers allocate their shipments to states in accordance with the population and to follow priority recommendations of state and local advisory committees in filling orders.

In letters to manufacturers, Surgeon General Burney declared that "we believe listing of essential personnel within a community can be done best at the community level."

Since the PHS did not go into detail on allocation of output in line with "state and local recommendations," this left the producers in a quandary. Vaccine is shipped as a rule to wholesale drug houses, pharmacists and retail men rather than to physicians or other high priority users directly. Consequently, the feeling among manufacturers was that the wholesalers were in better position to exercise control over the allocations of supplies.

The AMA pointed out that until sufficient vaccine becomes available to meet the demands, physicians will have to decide how best to conserve the supplies. Two methods of injection have been suggested. One calls for one subcutaneous injection of one cubic centimeter, the other for two intradermal injections of one-tenth of a cubic centimeter each.

"Until further information about the effectiveness of these two methods is available, the physician will have to decide for himself how the vaccine should be given to his patients," the AMA said.

Dr. Harold C. Lueth, chairman of the AMA's special committee on influenza, said that while industry will no doubt experience a marked increase in absenteeism this winter if the expected Asian influenza epidemic materializes, it should not get panicky and rush into a program of mass inoculation of employees until essential priority groups are first served.

In the priority list are persons engaged in health, police, fire, communications, transportation and utilities duties, along with those who in the opinion of physicians constitute a special medical risk.

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White coats on TV

Washington wants something done about visual representations in TV advertising, according to FDC Reports. As a result, the Federal Trade Commission is now pitting its wits against the antacid claims of Rolaids. Their prosecutors have selected products such as BiSoDol, Tums, and plain bicarbonate of soda as contrasts to prove false Rolaid's TV ad claims to be "twice as effective" and "twice as fast."

The hearings also may decide on a sore point among physicians—the "white coat" dramatization. The FTC charges that consumers are misled, thinking that an actor dressed in a white coat, and being addressed as "Doctor" is a real M.D. The implication is that the medical profession endorses Rolaids.

The FTC also objects to the scene in which hydrochloric acid supposedly burns a hole in a cloth napkin but when mixed with Rolaids—no burn. This goes back to the misconception that gastric juice will burn the lining of the stomach unless it is controlled.

Physicians agree with Capitol Hill and want this type of advertising eliminated from the air. They want no reference to the medical profession in the endorsement of any medication—nostrums or ethical products. Radio and TV are

long overdue for a code of ethics along this line. If the manufacturers, advertising agencies, and stations will not get together on a code, there is bound to be government intervention.

All this reeks of the old patent medicine spieler, barking from a wooden box, between bits of entertainment provided to attract the suckers.

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That 21 billion dollars— or black is white

Elmer V. McCarthy, M.D.

Old age and survivors insurance is, in the estimation of most rational economists, a far cry from anything known in this country as insurance. An institution which has the legal right to force one's money from him — even though it does imply theoretical financial benefit so unsound actuarially that any private concern offering the same terms would be closed up within twenty-four hours — is not offering the American concept of insurance.

The concept of social security is basically socialistic. It was never designed as a basic welfare innovation. Rather, it was intended as a veiled taxing device and a self-generating source of perpetual government power. That is precisely what it is today.

An example of the actuarial unsoundness of the plan is inadvertently revealed by Dr. Walter Bornemeier who, in the June 1957, issue of Illinois Medical Journal presents a plea for the adoption of this mirage by the medical profession. He states: "The doctors would pay less than $1,000.00 in social security taxes and become eligible for an average of $14,000.00 each. Today's aged would receive about fifty times what they paid in O. A. S. I." Now, inasmuch as this means money to be paid out by government, which money in turn is derived from no other source than the taxpayers, this scheme is analagous to an auto-transfusion with blood drawn from the left arm and infused into the right.

It must be perfectly obvious that if this scheme were financially possible, there would be no lack of private interests offering the coverage. The question arises: If the government can do it, why can't private interest? Again, the obvious answer is that private insurance companies operate under a great many governmental regulations and restrictions; they pay income taxes and they must have on hand a ready reserve of ASSETS at all times. Government regulates and approves itself, pays no income taxes and represents its DEBTS as ASSETS.

Specifically, the 21 billion dollars which Dr. Bornemeier assumes the government has in reserve is actually a 21 billion dollar government DEBT represented in the form of government bonds as an I. O. U. This money was first forced from the taxpayers. Next, the interest on these bonds was forced from the taxpayers. Finally, the public will again be forced to redeem these bonds through the medium of taxation. All of this with the taxpayer's money because the government has no money aside from what it gets from the taxpayers.

A government bond is a certificate of ownership of a specified portion of debt owed by the government; 21 billion dollars in government bonds is 21 billion dollars in government debt. The government is getting away with a token payoff at present because it is drawing on all tax monies received—not from a theoretical fund which is not and never was in existence. One wonders if there will be enough money in the world to pay off all insurance claims against this spurious fund in another twenty years.

Dr. Bornemeier states that the President, the Congress, Labor, the white collar class, college professors, dentists and lawyers are for social security. This statement is, of course, highly speculative, as the only groups polled in the matter have been the doctors and lawyers. It is true, as Dr. Bornemeier avers, that the doctors are against social security. At any rate they are against the fraud that presently parades as security. Among those who are presumed to be for social security are the welfare-staters, the new dealers, the modern Republicans, all the socialists and all the communists. It is to the credit of medicine that few of its members are found in these ranks. In the vanguard of resistance to the road to serfdom are the physicians and all others devoted to the free market, free enterprise, competition and limited constitutional government. There will always be those who are short-sighted enough to trade their heritage for a mess of pottage, but it is easy enough to understand the thinking of those who are tempted to risk less than $1,000.00 to gain $14,000.00,

particularly when this shell game is offered by politicians who at the moment control the government.

Social security, although a tremendously important issue today, is but one of the steps being pushed piece-meal by the social planners in their efforts to abolish the government of the United States and in its place create a membership in a communistic world government. Beware the Greek bearing gifts.

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Student loan fund praised

An interesting letter came recently from a young physician who received financial aid for his medical education from the Joint Medical Student Loan Fund, operated by the Illinois State Medical Society and the Illinois Agricultural Association. The letter was received by Mr. Ivan Parett, Secretary of the Joint Medical Student Loan Fund Committee, who likes to keep in touch with the large number who have obtained loans from the fund.

The Illinois State Medical Society and the Illinois Agricultural Association have a joint committee from the two allied organizations, to consider applications for assistance, and take final action in making the selections. Dr. Harlan English of Danville, is chairman of the State Medical Society Committee.

The young physician writing Mr. Parett said; "At the present time I am serving as division psychiatrist for the First Infantry Division at Fort Riley, Kansas. I will be released from the military on 1 July, 1958, and my present plan is to start a one year period of training in surgery at that time, in accordance with the provisions of my contract. Following the completion of that year (or in July, 1959) I intend to start a general practice in a small town in Illinois, preferably somewhere in the northwestern part of the state.

"It has been seven years since I sat in Dr. English's office on a Sunday afternoon and talked with you and him, and much water has gone under the bridge since then, but I'm sure I will never forget that day. It was, I'm sure, one of the most important days of my life, and it is hard to imagine where I might be or what I might be doing now, had it not been for the assistance you gave me. It is hard to believe that in less than two years I will be starting my own practice. I am still very enthusiastic about general practice and about the joint IAA and ISMS Student Loan Fund."

It is most encouraging to both of the co-operating organizations operating this fund to receive letters such as this one from a captain in the U.S.M.C., who is looking forward to becoming a general practitioner somewhere in rural Illinois.

Many letters of a similar type have been received by Mr. Parett and Dr. English, and we have every reason to believe that this will be a self perpetuating fund when a few more young physicians complete their military obligations and enter the general practioner field in Illinois.

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AMA clinical meeting in Philadelphia, December 3-6

The AMA's 11th annual clinical meeting will be held in Philadelphia, December 3-6. About 4,000 physicians are expected to attend.

Center of activities will be Convention Hall where scientific and technical exhibits, color television, motion pictures, and scientific lectures will be presented. There will be 120 scientific exhibits prepared by physicians and 160 technical exhibits presented by pharmaceutical houses, equipment manufacturers, and medical publishers.

Approximately 200 physicians will participate in lecture meetings, symposiums, and panel discussions on such subjects as cardiovascular disease, cancer, emotional problems of the menopause, hypertension, diabetes, arthritis, and injuries.

A special feature will be a trans-Atlantic conference between physicians in Philadelphia and London. The conference, on advances in chemotherapy of cancer, will be held via telephone at 3 p.m. (EST) Wednesday, December 4.

Closed circuit television clinics, featuring Philadephia physicians, will originate from Lankenau Hospital. A medical motion picture program is also being prepared.

Headquarters will be the Bellevue-Stratford Hotel, where the AMA House of Delegates, the Board of Trustees, and various councils and committees will meet.

The first action of the House of Delegates when it convenes Tuesday, December 3, will be to name the "General Practitioner of the Year."

AMA committees schedule meetings

Two committees of the AMA Council on Medical Service plan regional meetings Monday, December 2, in Philadelphia just prior to the AMA 11th Clinical Session. The Committee on Maternal and Child Care is holding its first regional meeting on prenatal mortality and morbidity. Invitations have been sent to members of maternal and child care committees in fourteen eastern states.

The Committee on Aging is holding its third regional conference for members of state committees on aging. Subjects to be discussed include physical examinations and a health maintenance program, guides for the organization and operation of medical society committees on aging, medical education in caring for the aged, preretirement counseling, and special research programs of a medical school. Physicians interested in attending either of these sessions should contact the AMA Council for further details.

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The new AMA research foundation

The American Medical Research Foundation was recently established by the AMA. Principal purposes for the Foundation will be; (1) to promote the betterment of public health through scientific and medical research; (2) to plan and initiate scientific and medical research, and (3) to collect, correlate, evaluate and disseminate results of scientific and medical research activities to the general public. Voting members of the Foundation will be members of the AMA Board of Trustees. Meetings will be held annually at the time of the AMA annual sessions.

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National employ the physically handicapped week

Governor William G. Stratton keynoted Illinois' observance of National Employ the Physically Handicapped week, October 6-12, with a dedicatory address at a dairy farm near Mt. Sterling, Brown County, which is operated by a blind person, Bernard L. Bunfill. The Governor's address was made at the Bunfill farm on Thursday afternoon, October 10.

The Bunfill farm is a 210 acre tract and it is the first of its kind to be operated in Illinois, and one of the first in the nation. The farm is sponsored by the Illinois Division of Vocational Rehabilitation and represents a major advance in services for the blind. It is the first unit in a recently established rural enterprises development for the blind and visually handicapped in Illinois, and is the result of an effort to train persons who become blind so they may return to the occupations they previously pursued.

Bernard Bunfill, owner of the farm, was born and brought up on a farm in the Mt. Sterling area. After engaging in farming for many years, he became a salesman for a creamery company. In 1955 an eye hemorrhage brought on sudden blindness. A home teacher from the field services of the Illinois Department of Public Welfare first worked with Bunfill to help him adjust to his blindness. Later the Division of Vocational Rehabilitation recommended that he return to the farm. With the help of rehabilitation counselors, Bunfill began operating his present farm about a year and a half ago.

He now has a herd of cows, and maintains his dairy at a high level of sanitation. Bunfill is one of 4,207 physically handicapped persons placed in remunerative employment by the Illinois Division of Vocational Rehabilitation during the past year.

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Civil defense conference aids county society planning

Information designed to help local medical and health personnel plan for their roles in disaster and civil defense was presented at the Eighth Annual County Medical Societies Civil Defense Conference in Chicago, November 9-10.

The conference was sponsored by the AMA Council on National Defense. Among the highlights were reports on the experience gained through several test operational exercises conducted under simulated disaster conditions.

It was pointed out that the effectiveness of medical preparedness plans was demonstrated last June when parts of Louisiana were struck by a hurricane. Prompt, organized response by medical personnel to appeals for help saved innumerable lives.

MEDICAL ECONOMICS



Specialization

Roland R. Cross, Jr., M.D., Chicago

THE mention of this word "specialization" is becoming the signal for starting an argument. Medicine argues over it so much that one might think it was purely a part of medicine, like anatomy, hospitals, physiology and laboratories. And yet a quick appraisal will reveal that it is not a characteristic of mericine alone. While it is true that practitioners of medicine seem to be of strong opinion as to its proper place, almost as if they fear that medicine will be ruined if it is not carefully controlled, still other fields have specialization without so much, although not devoid of, argument and sharp battle lines. In the field of law, many have become known as specialists in corporation law, constitutional law, real estate tax law, and the like. But closer in relation to medicine is our sister profession—dentistry. Dentistry is also developing specialization, but this has come about in a relatively quiet manner.

There are now seven fields of dentistry which have been recognized by the Council on Dental Education as specialties. The boards representing these dental specialties are as follows:

1. The American Board of Dental Public Health. This is more or less obvious in its scope.

2. The American Board of Oral Pathology. This covers the histological and gross changes of tissue disease of the oral cavity.

3. The American Board of Oral Surgery is concerned with surgery such as fractures, extractions, cysts and even cancer of the oral cavity. There is some overlapping with the ear, nose and throat physician in this field.

4. The American Board of Orthodontics. This group is concerned with the prevention and correction of irregularities of the teeth and malocclusion.

5. The American Board of Pedodontics is concerned with children.

6. The American Board of Periodontology is concerned with the tissues around the teeth and their diseases.

7. The American Board of Prosthodontics is the field of dental appliances and substitutes, such as crowns, bridges and dentures.

In discussing this recently with a professor in a leading dental school, it was learned that such specialization is proceeding just as steadily as is specialization in medicine. Any town of about 50,000 should be able to support a specialist in oral surgery. The Veterans Administration has almost two dozen such specialists. It would appear that specialization has hit the dental field about 15 years later than it did the medical field, but it is nevertheless here with us.

In keeping with such a trend, it must, as night follows day, develop a special training program. And so in many larger hospitals there are internships and residencies. A person wishing to aim toward such certification must spend two years in graduate or postgraduate courses, and, in addition, spend three years in practice devoted primarily to that specialty. Following this the candidate must pass the certifying examination. In addition, in some specialties, there is a separate examination given by the

State Department of Registration and Education, which is not true in the field of medicine.

As of 1956, Illinois has 35 oral surgeons, 75 orthodontists 6 prosthodontists, 11 periodontists, 7 pedodontists, 4 oral pathologists and no Public Health dentists. There are, undoubtedly, some who are aiming toward such certification of their specialization, but have not reached the point of being certified as yet. The dental schools graduate about 3,000 new dentists each year. The 1956 American Dental Directory lists 99,227 dentists, of which 89,000 are active in the profession. Of the 89,000 about 86,000 practice dentistry and 3,000 are engaged in teaching, research, administration, and so forth. Illinois has 6,233 dentists for a ratio of one per 1,513 people. Pulaski County is listed as having one dentist for 14,400 people; Edwards County has one dentist for 8,800; Cook County has one dentist per 1,215 people, and Morgan County has one dentist per 1,369 people. These are just examples. Illinois has 124 negro dentists with a negro population of 645,980, or one per 5,210 people, but it is assumed some negro patients go to non-negro dentists. The median net income of all dentists in Illinois was $12,039. Illinois has 104 hospitals with dental departments—this is 29.1 per cent of the hospitals in Illinois. This does not mean they are all approved by the American Dental Association. Of these hospitals, only 27 are approved. Five of these have approved internships and three have approved residencies for dentists.

According to the American Dental Association Journal, the expenses of independent dentists amounted to 43.5 per cent of the gross income in 1955. Dentists did best financially in towns of 50,000 to 100,000, 100,000 to 250,000, and in 250,000 to 1,000,000. Over 1,000,000 population in size produced a fall-off in income, but it did not fall as low as dentists earn in towns of 5,000 to 10,000. In general, a dentist is at peak earning power by age 40 to 44 and then slowly declines.

Specialists in dentistry reported a mean net income of $16,178, which was 36.8 per cent higher than the mean of general practitioners ($11,829). This was for all dentists. The differential was greater if one considered only independent dentists, for in this group the mean net income was $18,261 for specialists, which was 52.2 per eent more than for general practitioners (12,000). There is a tendency for a larger proportion of specialists to be salaried as compared to general practitioners.

Among the specialists, there was a still wider range for orthodontists had a mean net income of $21,181 and oral surgeons had a mean net income of $15,844, while at the bottom were prosthodontists with a mean net income of $10,082, but one must remember the smaller number of the latter.

Just as in anything else, the ability to organize pays off. A typical dentist with one chair and no employees earned $7,494 in 1955 compared to a dentist with three chairs and two assistants who earned $18,221 mean net income.

In hours of work per week, a general practitioner had a mean number of hours of 43.4 while an oral surgeon worked 37.9 hours, a prosthodontist had a mean of 36.8 hours and an orthodontist 41.3 hours.

There is a difference in the specialization picture in medicine as compared to dentistry. In medicine with the desire of the patient, the need for laboratory control and aid, as well as the growth of hospitalization insurance, there has developed a great utilization of hospital beds. People are more prone to use hospitalization. This brings the general practitioner's work into a central place where it is open to inspection and criticism by committees of the staff, of the hospital, and of accreditation agencies. On the other hand, the dentist in general practice is truly independent. His office is his castle and it has so far been uninvaded. He does not have to play politics to improve his staff position or to gain more privileges. He has no committees to inspect his work or his records. No autopsies are done so that Monday morning quarterbacking is a pastime. His primary criticism is his own conscience and standard of perfection. He has no pressure to refer cases to specialists save his own feeling of need for their aid. Will this so remain, or will the growth of this dental specialization bring a change in the practice of dentistry in the years to come? It is doubtful if anyone in 1930 would have envisioned the growth of specialization in medicine as it is today. As in all things, it will be interesting to see the change that years will bring.

CORRESPONDENCE



Clinics for crippled children listed for December

Twenty clinics for Illinois' physically handicapped children have been scheduled for December by the University of Illinois, division of Services for Crippled Children. The division will count 12 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing service. There will be three special clinics for children with cardiac conditions, two for children with rheumatic fever and three for cerebral palsied children.

Clinics are held by the division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

December 4 — Carmi, Carmi Township Hospital
December 4 — Hinsdale, Hinsdale Sanitarium
December 4 — Rock Island (Cerebral Palsy), Foss Home, 3808 8th Ave.
December 10 — E. St. Louis, Christian Welfare Hospital
December 10 — Effingham (Rheumatic Fever), St. Anthony Hospital
December 10 — Peoria, Children's Hospital, (St. Francis)
December 11 — Elgin, Sherman Hospital
December 12 — Springfield, St. John's Hospital
December 13 — Chicago Heights (Cardiac), St. James Hospital
December 17 — Belleville, St. Elizabeth's Hospital
December 17 — Peoria, Children's Hospital (St. Francis)
December 18 — Alton (Rheumatic Fever), Memorial Hospital
December 18 — Chicago Heights (General), St. James Hospital
December 18 — Elmhurst (Cardiac), Memorial Hospital of DuPage Co.
December 18 — Springfield (Cerebral Palsy), Memorial Hospital
December 19 — Bloomington A.M. (General), P.M. (Cerebral Palsy), St. Joseph's Hospital
December 19 — Rockford, St. Anthony's Hospital
December 20 — Chicago Heights (Cardiac), St. James Hospital
December 20 — Evanston, St. Francis Hospital

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Fellowships in allergy

The American Foundation for Allergic Diseases, 801 Second Avenue, New York 17, announced post-doctoral fellowships in research and clinical allergy.

The fellowships provide a stipend of $4,500 for the first year, $4,750 for the second year and

a two-year expense allowance of $750. Candidates must be graduates of approved medical schools and must have completed one or two years of graduate training required as a preliminary to certification by the Board of Internal Medicine or Board of Pediatrics.

Applications must be filed by December 15.

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American Board of Obstetrics and Gynecology

The Part I Examinations of the American Board of Obstetrics and Gynecology, are to be held in various parts of the United States and Canada, on Thursday, January 2, 1958, at 2:00 P.M.

Candidates notified of their eligibility to participate in Part I must submit their case abstracts within thirty days of notification of eligibility. No candidate may take the written examination unless the case abstracts have been received in the office of the Secretary.

Current Bulletins outlining present requirements may be obtained by writing to the Secretary's office. Robert L. Faulkner, M.D., American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio

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Ophthalmological clinical conference

The Chicago Ophthalmological Society will hold its annual clinical conference on February 21 and 22, 1958, at the Drake Hotel in Chicago, Illinois.

The guest speakers will include Dr. Wendell L. Hughes, Hempstead, N.Y., Dr. P. Robb, McDonald, Philadelphia, Pa., Dr. Phillips Thygeson, San Jose, California, Dr. Lorenz E. Zimmerman, Washington, D.C., Dr. Eugene R. Folk, Chicago, Illinois, Dr. Orville E. Gordon, Chicago, Illinois, Dr. William F. Hughes, Chicago, Illinois, Dr. Peter C. Kronfeld, Chicago, Illinois, Dr. David Shoch, Chicago, Illinois, Dr Derrick Vail, Chicago, Illinois and Dr. Howard L. Wilder, Chicago, Illinois.

The subjects will include a symposium on the complications of ophthalmic surgery, the zonule of the lens, glaucoma and retinal detachment surgery, plastic surgery techniques, management of glaucoma and cataract, melanotic tumors of the iris, and the structure of the vitreous.

Registration fee for the entire course, including round table luncheons and buffet supper is $45.00 and may be payable to the

Registrar, Mrs. Edward J. Ryan, 1150 North Lorel Avenue, Chicago 51, Illinois.

The Fourteenth Annual Samford R. Gifford Memorial Lecture will be delivered by Dr. Phillips Thygeson of San Jose, California, on Friday, February 21, 1958, at the Drake Hotel at 5:15 P.M. All ophthalmologists are invited to attend the Gifford Memorial Lecture and the buffet supper which follows.

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Announcement of the Van Meter Prize Award

The American Goiter Association again offers the Van Meter Prize Award of $300.00 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association which will be held in the St. Francis Hotel, San Francisco, California, June 17, 18 and 19, 1958, provided essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations, should not exceed 3,000 words in length and must be presented in English. Duplicate typewritten copies, double spaced, should be sent to the Secretary, Dr. John C. McClintock, 149½ Washington Avenue, Albany 10, New York, not later than February 1, 1958. The committee who will review the manuscripts is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for the presentation of the winning essay by the author.

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Traffic safety report

The Division of Traffic Safety, State of Illinois, Springfield, has available a limited number of reprints of an interview article with Governor Stratton which appeared in the magazine, Public Safety.

The article reflects the Illinois program of traffic safety and includes a progress report on recently enacted legislation.

The state's program is moving along. There was a 26 per cent reduction in fatalities in July and a 17 per cent drop in August.

THE P. R. PAGE



Overcharge views on wane

In February 1956, the AMA released the results of a comprehensive public survey covering every aspect of patient-physician relationship.

One of the questions asked concerned charges. Forty-three per cent of the answers said physicians overcharged, although only 16 per cent held that view about their own family doctor.

More recently, Elmo Roper, the pollster, conducted a survey. It is interesting to note that 32 per cent of the populace believes the medical profession is overcharging.

This reduction, from 43 per cent to 32 per cent, is an encouraging development. It indicates that the public relations efforts of the medical profession are bearing fruit through: (1), the public's realizing that on the whole physicians' charges are not out of line with conditions, and (2), physicians who were guilty of overcharging in the past are being more conservative in their bills.

There is one disconcerting note in the Roper poll. He found overcharging complaints reached 39 per cent in small towns, as against only 23 per cent in big cities. This caused him to comment that something has gone amiss with the "folklore" that the citadel of the family physician is the small town.

If it is any solace, Roper's poll also showed that the public believed it was being overcharged by others as well: plumbers, 29 per cent; dentists, 23 per cent; landlords, 21 per cent; electricians, 19 per cent, and auto mechanics, 19 per cent.

Public relations in the office

A medical practice management consultant is quoted in *Medical Economics* as saying:

"If your secretary ever begins acting as if she were conferring favors on your patients by giving them appointments or accepting their checks, better start looking for somebody new."

Behind this advice is the experience that no matter how fine a service is renderd by a physician his relationship with his patients may suffer because of the antagonism which may be aroused by impolite office help.

Physicians sometimes wonder why a patient does not return although he or she appeared to be satisfied on departing. It is possible that something happened on the way out.

Good public relations starts in the physician's office. However, it not only involves him but his help as well. Consequently, for the maintenance of a good relationship with patients, an occasional check on the manner in which office personnel operates is excellent preventive medicine.

If you can't speak kindly, don't speak

The analysis of 661 professional liability claims and suits which appeared in the Journal of the AMA, October 5, 1957, page 608, pro-

(*Continued on page 247*)

AT THE EDITOR'S DESK



ONE hundred and twenty papers were presented at the Fifth Annual Antibiotics Symposium in Washington in October. A new Czechoslovakian chemical, antibiolymphins, is said to direct antibiotics to certain tissues. The new compound has been used with Chloromycetin and in all probability will be combined with other antibiotics or medicinals for the same purpose. The localized effect may be useful in cancer therapy and diagnosis.

The FDA antibiotic research survey revealed that during the past three years almost 900 serious penicillin reactions have been reported. There were 72 anaphylactic fatalities; 63 stemmed from intramuscular penicillin and nine from combinations of IM penicillin and streptomycin. No deaths were reported from oral penicillin.

The first drug for specifically combating penicillin reactions was reported at this meeting. It is Neutrapen (Schenley), a penicillinase product, that is said to be the only agent that destroys the inciting penicillin antigen.

Panalba is a combination of PANmycin phosphate plus ALBAmycin. Upjohn is recommending this product to combat resistant strains of staphylococci. This pharmaceutical house is presenting new Medrol. They say it is the most efficient and best tolerated of all anti-inflammatory corticosteroids. A methyl group has been substituted for hydrogen in the 6-alpha position of prednisolone. The company states that Medrol produces full therapeutic effects with a dosage one-third lower than prednisolone and that relief is obtained with less edema, gastric distress, and psychic stimulation. The low salt diet is not needed.

Lilly issued news releases on V-Cillin K, their new oral penicillin; Darvon, a non-narcotic pain reliever; and liquid Trisogel, an aromatized aqueous suspension of aluminum hydroxide and magnesium trisilicate. Darvon is effective by mouth, low in toxicity, and is compatible with other drugs, including analgesics.

Lakeside has a new intramuscular iron product, Imferon, which is reported to be "free from toxic reactions, either local or systemic," after clinical trials.

Abbott announced the introduction of TRAL, a new anticholinergic drug. It has been subjected to extensive clinical investigation, with reports from 71 physicians on more than 1,000 cases. Good and excellent results were reported in 80 per cent of patients with peptic ulcer or "various functional and spastic conditions of the gastrointestinal tract."

Verazide, a new derivative of isoniazid, is

said to be superior to the parent drug and is less toxic and longer lasting. Much of the research has been done in Australia and South Korea. There are rumors also of a method of speeding up the guinea pig test for tuberculosis. It is done by injecting the suspected material into the brain of the animal. Tuberculous meningitis develops in 15 to 31 days.

A combination of nitrogen and prednisone was found useful in the treatment of nephritis and nephrosis. Permanent cure was obtained in 15, improvement in seven, and failure in five of 27 patients. This report comes from Austria.

Parke-Davis was granted a U.S. government license to market an adenovirus vaccine. It will be prepared from sero-types 3, 4, and 7 which have been identified with certain acute respiratory and conjunctival infections. The chief features of pharyngoconjunctival fever are follicular conjunctivitis, pharyngitis, rise in temperature, cervical lymphadenopathy, and rhinitis. Immunization lasts as long as four months after a 1 cc. injection. Thereafter, a booster shot will be needed.

The Borden Company's Prescription Products Department is offering a series of long playing records on pediatric allergy. Each disk is a postgraduate course in itself. They call these L. P.'s their clinical conversation pieces.

A group of Windsor, Ontario, pharmacists have started the first Group RX Insurance program in North America. It is patterned after hospital and medical programs and the new service will fill all prescriptions of subscribers at an expected average annual cost of $10 per person. Similar proposals for flat rate group service have been advanced in the U.S.A. from time to time but were opposed by organized pharmacy.

The Centimeter Club is one of Boston's easiest clubs to join. The only requirement for membership is that the physician record the blood pressure in centimeters, as is done in France, Greece, and Mexico, rather than in millimeters. Dr. James H. Currens, of Massachusetts, says: "It is rather foolish to use millimeters in expressing a reading that is seldom accurate to more than the nearest 10 millimeters or one centimeter."

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THE P.R. PAGE (continued)

vides food for thought from a public relations standpoint.

In the majority of case histories reported it was indicated that some factor in addition to the alleged negligent act prompted the individual to file a claim or suit. Heading the list of secondary factors was careless comment about another physician. That reason was reported in 25.2 per cent of cases.

Contrast this with 15.4 per cent of actions prompted by attorneys and 7.2 per cent by relatives and one may realize the damaging effect of a thoughtless or careless comment about a colleague.

It doesn't help medical public relations to run down a fellow member.

NEWS of the STATE



ADAMS

The regular monthly meeting of the Adams County Medical Society, held at the Hotel Lincoln-Douglas, Monday evening, Oct. 14, was a joint meeting with the Adams County Bar Association. The fellowship hour was followed by a dinner, after which, Mr. Walter Oblinger of Springfield, Associate Counsel of the Illinois State Medical Society, addressed the meeting. Mr. Oblinger related and highly commended the work of the impartial medical testimony plan in personal injury suits that has been in effect in New York City since 1952. This was originally supported by grants from the Sloan and the Ford Foundations. Mr. Oblinger's address was followed by a sound film entitled "The Medical Witness" produced jointly by the American Medical Association and the American Bar Association. A general discussion followed the talk and film presentation.

At the business session, Dr. Wm. S. White of Quincy, who has been a member of the Illinois State Medical Society at Springfield, Ill., for some years, was elected to membership in the local society. The next monthly meeting of the society, on November 11, will be devoted to Civil Defense, and Dr. Charles L. Maxwell of Chicago, Deputy Director for Health, State of Illinois, will be the speaker. All Quincy workers in civil defense, including the members of the Woman's Auxiliary to the Adams County Medical Society, will be invited to attend.

New Medical Director.—Dr. W. H. McCain, internist at St. John's Sanitarium and Crippled Children's Hospital, Springfield, has been appointed medical director of Hillcrest Sanitarium, Quincy. He succeeds Dr. Clare Miller, who resigned, October 16, after twenty-seven years' service.

Personal.—Dr. John P. Wood, who recently retired from the U. S. Navy, in which he held the rank of captain, with more than twenty-nine years' service, has become associated with Drs. Gordon M. Perisho and Kenneth H. Vinnedge, Quincy. His practice will be confined to radiology.—Dr. Ralph F. Davis, who recently completed two and one half years as chief of radiologic service at the Veterans' Administration, Wadsworth, Kan., has become associated with Dr. Harold Swanberg, Quincy.—Dr. B. J. Rodriguez, recently of Antioch, has established practice in Barry.

CHAMPAIGN

Postgraduate Conference.—The Committee on Postgraduate Medical Education and Scientific Service of the Illinois State Medical Society and the faculty of Northwestern University Medical School presented a postgraduate conference at the Elks Club, Champaign, November 14, with the Champaign County Medical Society acting as host. Presiding officers were Drs. William H. Schowengerdt, Champaign, a member of the state society's committee, and James D. McKinney, Champaign, president of the county medical society. Speakers were Drs. David Hsia, associate professor of pediatrics; F. John Lewis, professor of surgery; Walter J. Kuhl, Jr., assistant professor of medicine and Melvyn Bayly, associate in obstetrics and gynecology. Discussants were Drs. Myron Korry,

Joseph B. Seagle, John H. Gernon, Homer A. Hindman, Jr., Phil A. Daly, Charles H. Drenckhahn, Carl Greenstein and Thomas R. Wilson.

At the dinner meeting, Dr. John T. Graynack, assistant professor of urology and director of the Kretschmer Memorial Laboratory, spoke on "Common Urological Problems," and Dr. Harlan English, Danville, Councilor of the Eighth District, "Medical Organization."

A dinner meeting of the Champaign County Woman's Auxiliary was addressed by Dr. James R. Hines on "Europe Today."

COOK

Surgeons Choose Officers.—Dr. Charles B. Puestow was recently elected president of the Chicago Surgical Society. Other officers include Drs. John L. Keeley, vice president; J. Garrott Allen, secretary; Burton C. Kilbourne, treasurer; Richard J. Bennett, recorder, and Geza deTakats, John M. Dorsey, and Earl Garside, councilors.

Hospital News.—A $250,000 neurosurgical nursing floor was dedicated, September 8, in Billings Hospital. Known as an intensive nursing area, it is devoted solely to the treatment of persons recovering from brain operations. The new unit was financed by funds from the university, grants to the university and by the Goldblatt Brothers Employees Nathan Goldblatt Cancer Research fund.

Dr. Dorfman Receives Award.—The Mead Johnson Award of the American Academy of Pediatrics was recently presented to Dr. Albert Dorfman, professor of pediatrics, University of Chicago School of Medicine, and director of La Rabida Sanitarium. The honor was in recognition of Dr. Dorfman's work on connective tissues. In a talk following his acceptance of the award, he reviewed his research on the polysaccharides, eight of which are produced by the connective tissues and not normally excreted. The Mead Johnson Awards, established in 1938, are given for pediatric research. They include an honorarium of $1,000 and a certificate and are given annually for research, the results of which have been published in the previous calendar year.

Karl Meyer Honored.—More than 1,200 persons attended a testimonial dinner, September 30, given in honor of Dr. Karl A. Meyer, superintendent of Cook County Hospital, and to mark the opening of a $750,000 fund raising campaign for the Chicago Foundling Home. Mrs. Salvatore Ferrara, general chairman of the dinner, held in the Sherman Hotel, presented Dr. Meyer, president of the home's board, with a check for $93,000. The money represented the $50 a plate paid by the guests and other contributions, newspapers reported. On October 2, Dr. Meyer was honored by the Chicago Medical Society at its Annual Dinner, marking his completion of a term as President of the Society. On this occasion he was presented with a wall clock for the Foundling Home. In his speech of acceptance, Dr. Meyer stated that "next to the Chicago Medical Society, his love was for the Foundling Home."

Personal.—Dr. Attallah Kappas, associate member in the division of steroid metabolism, Sloan-Kettering Institute for Cancer Research, New York, and a graduate of the University of Chicago School of Medicine, has been appointed assistant professor of medicine at the university's Division of Biological Sciences. He will be in charge of the section on arthritis at the University of Chicago Clinics.—Dr. Louis B. Newman, Chicago, was recently named president-elect of the American Academy of Physical Medicine and Rehabilitation. Dorothea C. Augustin, Chicago, is executive secretary of the academy with offices at 30 North Michigan Avenue, Chicago 2.—Dr. Francis E. Senear, emeritus professor and head of the department of dermatology, was recently elected president of the International Congress of Dermatology. He has served in a similar capacity with the Chicago Dermatology Society, The American Dermatology Association, and the American Academy of Dermatology and Syphilology.—Dr. James N. Waggoner, assistant district medical manager of United Air Lines, has been named manager of the line's new medical center in Los Angeles. He has been succeeded in Chicago by Dr. James Keehan, a former flight surgeon in the U. S. Air Force and recently engaged in private practice.—Dr. Roy M. Whitman, associate professor of psychiatry and neurology, Northwestern University Medical School, has resigned to become associate professor of psychiatry at the University of Cincinnati College of Medicine.

Special Lectures.—The twenty-ninth annual Arthur Dean Bevan Lecture of the Chicago Surgical Society was recently presented by Dr. Michael E. DeBakey, Judson L. Taylor professor of surgery, Baylor University College of Medicine, Houston, Texas. His subject was "Changing Concepts in Aortic and Arterial Surgery."—"The Evolution of Anatomy" was the title of the first lecture in a series on surgery being sponsored by the International College of Surgery. Dr. H. W. Magoun, department of anatomy, University of California Medical School, Los Angeles was the speaker.—Dr. J. Roswell Gallagher, Boston, delivered the fifth Harry Remer Memorial Lecture at La Rabida Sanitarium recently on "Medical and Emotional Problems of the Adolescent Patient." Dr. Gallagher is chief of the adolescent unit at Children's Medical Center, Harvard University, Boston.—Prof. Ian Aird, chief of the surgical service and head of the department of surgery, at the postgrad-

uate medical school of the University of London, England, gave the Charles H. Mayo Memorial Lecture at Northwestern University Medical School, October 25, on "Pancreatectomy."

Physicans are appointed to Chicago Board of Health.—Dr. Lowell T. Coggeshall, dean of the division of biological sciences of the University of Chicago, and Dr. Theodore K. Lawless, dermatologist, have been appointed to the Chicago Board of Health, newspapers reported.

The appointments were in accordance with an ordinance past last June, increasing the board from five to nine members. Two places remain to be filled.

Dr. Coggeshall was chairman of the department of medicine at the University of Chicago when he resigned in 1949 to devote full time to research and to his duties as dean of the division of biological sciences. He is president-elect of the American Cancer Society and of the Association of American Medical Colleges.

Dr. Lawless has received several awards for his accomplishments in medicine and for his service to the Negro race.

Dinner to Honor Dr. Sheinin.—On November 26 a dinner will be held in the Grand Ballroom of the Conrad Hilton Hotel to honor Dr. John J. Sheinin on the twenty-fifth anniversary of his association with the Chicago Medical School. The occasion will also launch a drive for $3,600,000 for an expansion program for the school, which recently received a grant of $1,000,000 from the U. S. Public Health Service for a new medical and research building. Dr. Sheinin joined the staff of the medical school in 1932 as head of the department of anatomy. He was made dean in 1935 and elected president in 1950. Harvey Kaplan, vice president and treasurer of the M. S. Kaplan Company, has been named chairman of the anniversary dinner, which is expected to attract more than 1,500 persons.

Faculty Appointments.—The following physicians have been named to the faculty of Chicago Medical School: Catherine K. Cullinan, associate in psychiatry; Stefan A. DeKowski, clinical assistant in neurosurgery; Seymour Fishkin, instructor in medicine (full time); Melvin G. Goldzband, clinical assistant in psychiatry; Jacob Ladenheim, clinical assistant in ophthalmology; Nathan Schlessinger, associate in psychiatry; Peter B. Segal, associate in gynecology and obstetrics, and Jacob Ungar, clinical assistant in medicine.

Dr. Slayton Named to New Position at St. Luke's.—Dr. Robert E. Slayton has been appointed director of medical education at St. Luke's Hospital, Chicago. In this newly created position, Dr. Slayton's duties will be to strengthen and direct the educational program for the intern and resident staff. A graduate of the University of Chicago School of Medicine, Dr. Slayton interned at the Cleveland City Hospital. He completed a two year residency at St. Luke's in 1943 when he went to the Joslin Clinic in Boston; subsequently he served as a lieutenant in the U. S. Navy.

Paul Cannon Retires—Succeeded by Robert Wissler.—Dr. Paul Cannon retired as professor and chairman of the department of pathology at the University of Chicago School of Medicine, effective September 30. He has been succeeded by Dr. Robert W. Wissler, professor of pathology. Dr. Cannon has been on the medical faculty for thirty-two years, serving for the last seventeen as professor and chairman of the department. As professor emeritus, he will maintain an office and will continue as chief editor of the American Medical Association's Archives of Pathology. As a medical scientist, Dr. Cannon is best known for his work on tissue antibodies and on foods the body needs to maintain them. For his work in immunity and nutrition, Dr. Cannon was awarded in 1948 both the Ward Burdick Medal of the American Society of Clinical Pathologists and the William Wood Gerhard Gold Medal of the Pathological Society of Philadelphia.

Dr. Wissler, who has been associated with the university since 1941 both as a student and teacher, in 1947 received the Howard Taylor Ricketts Medal for outstanding research by a student in pathology and bacteriology and in 1952 the Joseph A. Capps Prize of the Chicago Institute of Medicine for producing hardening of coronary arteries in animals.

Physicians Retire.—Dr. George F. Munns, Winnetka, officially retired from the active practice of medicine, October 3. Dr. Munns, professor of pediatrics at Northwestern University Medical School, and a staff member of Children's Memorial Hospital, and his wife, will make their home in Palm Desert, Calif.—Dr. A. E. W. Jourdan was guest of honor at a dinner recently, given by the staff of Martha Washington Hospital to mark his retirement after fifty-two years in the practice of medicine and ending his membership on the hospital's staff after thirty years' service. Dr. Jourdan had served as president of the staff from 1946 to 1952.

Scientists Named to New Honors at Chicago.—William Bloom, professor of anatomy and member of the committee on biophysics, has been named Charles H. Swift Distinguished Service Professor at the University of Chicago Division of Biological Sciences, and Heinrich Kluver, professor of experimental psyehology, has been designated Sewell L. Avery Distinguished Service Professor. Dr. Bloom, a member of the Chicago faculty since 1900, is particularly well known among biologists for his studies of cellular growth and behavior, cellular division,

the processes of formation of blood and bone, and general histology. Dr. Kluver was the first to study eidetic imagery (visualizations with the character of reality) and eidetic memory in children. In recent years he has made contributions to the chemistry of the brain and developed a new method for staining nerve cells and nerve fibers which is being widely used in hospitals and laboratories.

Movie Wins Honors.—Dr. Hans Von Leden and Paul Moore, Ph.D., both of the faculty of Northwestern University Medical School, recently won two awards for their movie on "The Function of the Normal Larynx." The awards were the "Minerva, or first prize, from the International Film Festival for Medical and Scientific Films, Turin, Italy, and a silver robot, or special award, from the III International Congress for Specialized Cinematography, Rome. The latter was in recognition for the perfection of a new technique in recording laryngeal function by high speed photography.

Refresher Course.—The Medical Alumni Association of the University of Illinois announces sponsorship of a Fall Medical Refresher, to be held November 23, on the University's professional colleges campus in Chicago. Announcement of the event was made recently by Dr. John P. O'Neil, President of the Medical Alumni Association.

The day-long affair, first of its kind at the College of Medicine, will consist of panels and open symposiums on current medical problems, moderated by key faculty members. Tours of the hospitals and Medical College with a social hour and dinner at the Illini Union Building are also part of the many activities planned.

Medical alumni from the University of Illinois now total nearly 6,000 physicians from the nation's third largest medical college, with a current enrollment of 650 students.

Present Association plans to make such medical refreshers twice-annual events reflect new and vigorous expansions of the University of Illinois medical alumni activities and are designed to combine homecoming reunion pleasures with current medical developments for the Illini physicians.

Dr. George W. Moxon of Chicago and Dr. Marcus R. Caro of the College of Medicine faculty are in charge of arrangements.

GREENE

Society News.—Dr. Frederick W. Falls, emeritus professor of obstetrics and gynecology, University of Illinois College of Medicine, addressed the Greene County Medical Society, September 17, in White Hall. His subject was "The History of the Committee on Maternal Welfare in Illinois: Its Aims and Purposes."

KANKAKEE

Dr. Odom Retires.—Dr. Cleve C. Odom, medical superintendent of Kankakee State Hospital, has retired, effective October 16. He will be succeeded by Dr. Armin H. Wolff, who holds a similar position at East Moline State Hospital.

KNOX

Society News.—At a meeting of the Knox County Medical Society in Galesburg, September 19, Dr. Robert J. Jensik, Chicago, clinical associate professor of surgery, University of Illinois College of Medicine, spoke on "Surgical Management of Pulmonary Diseases."

LAKE

New Members.—The transfer of membership of the following three physicians into the Lake County Medical Society has been approved: Peter S. Teresi, Grayslake, from the Chicago Medical Society; Bernard M. Kaye, Highland Park, from the Polk County (Iowa) Medical Society, and John P. Risley, Waukegan, from the Washington County (Maryland) Medical Society. The society also accepted into membership the following physicians: Joseph Tauchas, Lake Villa; Ceslovas Kizlauskas, Fox Lake, and Anthony Ciuris, Lake Zurich; Sergio L. Fuentes and Dulce M. Milanes, both of Grayslake.

LA SALLE

New Officers.—Dr. Martin Rosenthal, La Salle, was recently elected president of the La Salle County Medical Society. Other officers are Drs. R. R. Musick, Mendota, vice president; R. J. Bailey, Ottawa, and J. S. Geen, Utica; J. W. Geiger, La Salle, and E. D. Seymour, Streator, members of the board of censors. Drs. W. A. Scanlon, and J. B. Aplington, both of La Salle, are delegate and alternate, respectively, to the Illinois State Medical Society.

Postgraduate Conference.—On October 24 a postgraduate conference was held at the Kaskaskia Hotel, La Salle, under the auspices of the Committee on Postgraduate Medical Education and Scientific Service of the Illinois State Medical Society and the faculty of Stritch School of Medicine of Loyola University, and with the La Salle County Medical Society acting as host. Presiding officers were Drs. George E. Kirby, Spring Valley, Co-Chairman of the state society committee, and E. G. Barton, Streator, president of the county medical society. Participants in the afternoon scientific program were Drs. Peter J. Talso, John R. Tobin, George W. Ferenzi, Joseph V. Condton, Charles S. Gilbert, John J. O'Brien, all of the department of medicine; Joseph R. Christian, professor of pediatrics, and Joseph T. Coyle, clinical associate in bone and joint surgery. Subjects included "Electrolyte and Fluid Problems" (surgery, pediat-

rics and congestive heart failure); "Collagen Disease: Emphasizing Disseminated Lupus Erythematosus", "Hypofibrinogenemia" and "Fractures in Children." Discussants were Drs. Dexter Nelson, Jerome F. Sickley, William J. Farley, Russell Simonetta and B. J. Doyle.

The dinner speakers were Drs. Joseph T. O-'Neill, Ottawa, Councilor of the Second District, on "Medical Organization", and Lester S. Reavley, Sterling, President of the Illinois State Medical Society, on "The Medicare Program."

PEORIA

Personal.—Dr. Jay C. Alameda announces the opening of his office for the practice of orthopedic surgery in the First National Bank Building, Peoria.

Society News.—At a meeting of the Peoria Medical Society in the University Club, Peoria, October 15, Mr. Edward J. Holman, staff assistant, Law Department, American Medical Association, spoke on "Malpractice." In September the society was addressed by Dr. Edward Reinhard, professor of medicine, Washington University School of Medicine, St. Louis, on "Chemotherapy of Neoplastic Disease."

SANGAMON

Auxiliary Meets with Medical Society.—On October 3 a joint meeting of the Sangamon County Medical Society and its Woman's Auxiliary was held in the Leland Hotel, Springfield. Speakers were Dr. J. Otto Lottes, assistant professor of orthopedic surgery, Washington University School of Medicine, St. Louis, on "Intramedullary Nailing of Fractures" and members of the League of Women Voters on the "League's Realm and Responsibility."

VERMILION

Society News.—Dr. Eugene M. Regen, associate professor of orthopedic surgery, Vanderbilt University School of Medicine, Nashville, discussed "Low Back Pain" before the Vermilion County Medical Society at its dinner meeting, October 1, in the Hotel Wolford, Danville.

New Members.—Drs. W. F. Hensold and R. G. Bowen have been unanimously approved for permanent membership in the Vermilion County Medical Society, both having completed their probationary year.

GENERAL

State-Wide Public Health Committee.—Dr. Lester S. Reavley, Sterling, President of the Illinois State Medical Society, gave the principal luncheon address during the thirteenth annual meeting of the Illinois State-Wide Public Health Committee in Starved Rock Lodge, Starved Rock State Park, October 16. His subject was "The Illinois State Medical Society and the Full-time County Health Department." Benjamin Wham, chairman of the state-wide committee, presided, and Dr. Roland R. Cross, Springfield, director of the Illinois Department of Public Health", gave the address of welcome. A feature of the afternoon program was a report on the recently created health unit in Lake County. Mrs. Orville Foreman, Jacksonville, is the new co-chairman of the state-wide public health committee, succeeding Mrs. Margaret B. Cowdin, Springfield.

Shortage of Cadavers.—A six-part program has been proposed by a committee of the National Society for Medical Research to relieve the increasingly serious shortage of cadavers threatening the quality of medical education in the United States.

"A majority of medical colleges report that they are unable to obtain enough bodies to teach student doctors efficiently," Dr. Oliver P. Jones, head of the anatomy department at University of Buffalo Medical School and chairman of the committee said. "Some schools have been forced to drop such important courses as surgical anatomy."

The committee's program includes:

1.) A survey of public opinion toward anatomical studies.

2.) A series of conferences with religious leaders, public welfare administrators, undertakers, hospital superintendents and other persons concerned with the disposition of bodies.

3.) A program of education for persons in the health professions.

4.) A general public educational program.

5.) The drafting of modern laws making bodies available through bequest (in 39 states, a person's body is not his own to give after death.)

6.) Legal reference service, with standardized forms and procedures for bequeathing a body to a medical school.

In the opinion survey, a depth-interview study that will discover underlying sentiments has been proposed. Results of the study will provide a foundation for the other five elements of the program.

Members of Dr. Jones' committee are Dr. Benjamin Spector, professor of bio-anatomy and history of medicine, Tufts University School of Medicine; and Father Thomas J. O'Donnell, regent, College of Medicine and Dentistry, Georgetown University. The group met in Buffalo September 6 and 7.

Dr. Jones explained that "Changing times, plus outmoded laws and ancient prejudices mean increasing trouble for the anatomy departments of many of American's medical colleges."

The University of Buffalo alone operated its anatomy department last year with 23 cadavers short of adequate instruction. It was not able to give anatomical instruction to nurses and people in the public health fields. The department used 37 bodies to instruct 68 dental and 80 medical

students. "This means four students to each body," Dr. Jones explained.

"If we have to assign a larger number of students to each cadaver, as we will if the shortage continues, students will not get proper experience in dissection. And they will be inadequately prepared when they subsequently have to operate on living patients."

Food Crusade for CARE.—Contributions are now being received in CARE's 1957 Food Crusade, the aim of which is to send food packages into twelve foreign areas. A single dollar will provide food for an entire month for one family. The food, which consists of milk powder, cheese, flour and cornmeal, is given free to CARE by the U. S. Government, and the dollar contribution pays the packing, shipping and distribution costs of one 22-pound package to the following areas: Ceylon, Colombia, Greece, Hong Kong, West Germany and Berlin, India, Israel, Italy, Korea, Macau, Pakistan, Peru and Yugoslavia. CARE is the abbreviation for Cooperative for American Remittances to Everywhere, Inc. For every single dollar contribution received, CARE can send 22 pounds of food overseas; $10 will feed forty people for one month, and $100 will deliver one ton of food to a needy village, orphanage or refugee camp. Contributions may be sent to CARE, Chicago, or directly to CARE, 660 First Avenue, New York 16. Principal Railway Express Agency offices also accept CARE food crusade contributions as a public service. Contributions are income-tax deductible.

New "Ob. and Gyne" Officers.—Dr. Harold E. Smith, Maywood, was named president-elect of the Illinois Obstetrical and Gynecological Society recently and Dr. Ray E. Bucher, Danville, was inducted as president. Other officers are Drs. Gilbert H. Edwards, vice president, Pinckneyville; Mary Louise Newman, Jacksonville, secretary; David M. Jenkins, Bloomington, assistant secretary, and Ralph N. Redmond, Sterling, treasurer. Meetings of the society are held the third Thursday in January, the day before the opening meeting of the Illinois State Medical Society in May and in August. Applications for membership in the society may be obtained from Dr. Newman, secretary of the society.

Change in Name for Medical Assistants.—At its first state meeting in Quincy recently, the Illinois State Medical Secretaries and Assistants Association changed its name to the Illinois Medical Assistants Association. This progressive group, which is rapidly expanding both in membership and activities, brought out its first official News Letter in September. It is to be published eight times a year. Jessie Breinig, 187 North Marion Street, Oak Park, is editor. Officers of the association include Elvera Fischer, president, Chicago; Thelma Newberry, president-elect, Quincy; Virginia Browning, Chicago, and Melba Johnson, Quincy, vice presidents; Marietta Munnis, Chicago, secretary and Darlene Howard, Quincy, treasurer.

Lectures Arranged Through the Illinois State Medical Society:

Thomas F. Kruchek, clinical assistant in psychiatry, Stritch School of Medicine of Loyola University, Toman Branch Library Forum, November 8, on "The Tranquilizer Question."

Francis O. Lamb, psychiatric consultant, Glenwood School for Boys, Women's Council of Max Straus Center, November 26, on "Keep Yourself Mentally Trim."

John A. Mart, associate in medicine, Northwestern University Medical School, LaSalle County Medical Society at the Highland Sanitarium in Ottawa, October 10, on "Chest Diseases."

John M. Reichert, instructor in pediatrics, Northwestern University Medical School, Whiteside and Lee County Medical Societies at Gordon's Restaurant in Sterling, October 17, on "Common Pediatric Problems."

Joseph H. Garthe, staff pediatrician at St. Anthony's Hospital in Rockford, Stephenson County Medical Society at the Hotel Freeport in Freeport, November 21, on "Common Pediatric Problems."

DEATHS

Emanuel Morris Arnovitz*, Granite City, who graduated at St. Louis University School of Medicine in 1924, died July 8, aged 60. He was a member of the staffs of the Missouri Baptist Hospital, St. Louis, and St. Elizabeth Hospital in Granite City.

August A. Bauer*, Kankakee, who graduated at the Chicago Medical School in 1928, died in July, aged 61.

Edmond Bechtold*, Belleville, who graduated at Washington University School of Medicine, St. Louis in 1915, died July 16, aged 65, of coronary thrombosis. He was past president of the Belleville Branch, St. Clair County Medical Society, and a member of the staff of St. Elizabeth's Hospital.

Bert M. Brewster*, Jerseyville, who graduated at Washington University School of Medicine, St. Louis, in 1905, died August 21, aged 75.

John J. Davies*, Moline, who graduated at

*Indicates member of the Illinois State Medical Society.

State University of Iowa College of Medicine in 1941, died in August, aged 42.

Harold W. Dingman, Chicago, who graduated at the University of Toronto Faculty of Medicine, Montreal, in 1905, and at Grand Rapids Medical College, Michigan, in 1906, died September 30, aged 73. He was vice-president and former medical director of Continental Assurance Company.

Robert Flentje*, Springfield, who graduated at St. Louis University School of Medicine in 1906, died in St. John's Hospital July 16, aged 76. He was past-president of the Sangamon County Medical Society.

Arthur L. Hagler*, retired, Milwaukee, formerly of Decatur, who graduated at Rush Medical College in 1899, died June 1, aged 88.

Carl J. E. Helgeson*, Chicago, who graduated at Rush Medical College in 1927, died October 7, aged 61. He was a member of the staff of the Illinois Central Hospital.

Karl J. Henrichsen*, East Moline, formerly of Chicago, who graduated at Loyola University School of Medicine in 1916, died September 21, aged 78. He was medical superintendent at the Municipal Tuberculosis Sanitarium from 1933 to 1948.

James Jacob Hoffer, retired, Chicago, who graduated at National Medical Univesrsity, Chicago, in 1907, died in Long Island, New York, July 15, aged 79. He was also a dentist.

Henry Frederick Kallenberg, River Forest, who graduated at Northwestern University Medical School in 1900, died at the YMCA Camp near Estes Park, Colo., where he was recreation director, July 25, aged 91.

Robert Leonidas Kane*, Herrin, who graduated at St. Louis University School of Medicine in 1910, died July 8, aged 72, of uremia. He was a member of the staff of Herrin Hospital.

Henry Lowry Knowles, Peoria, who graduated at the College of Medicine and Surgery (Physio-Medical), Chicago, in 1903, died May 13, aged 80.

George J. Kruk, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1904, died September 25, aged 82.

Harold W. Luesssman*, retired, Chicago, formerly of Evanston, who graduated at Loyola University School of Medicine in 1923, died September 14, aged 59. He was a former member of the staff of St. Francis Hospital, Evanston.

Herbert O. Lussky*, Evanston, who graduated at Rush Medical College in 1917, died September 26, aged 70. He was a member of the staffs of Evanston and St. Francis Hospitals, and a former staff member of the Children's Memorial Hospital.

Sidney L. Mann*, Summit, who graduated at Bennett Medical College, Chicago, in 1913, died October 8, aged 70. He was a member of the staff of Holy Cross Hospital in Chicago.

Robert E. Moran*, retired, Fort Lauderdale, Florida, formerly of Chicago, who graduated at Loyola University School of Medicine in 1926, died recently, aged 61. He was former house physician at the Palmer House and a member of the staff at St. Francis Hospital, Evanston.

Louis Ostrom*, Rock Island, who graduated at Missouri Medical College, St. Louis, in 1899, died August 5, aged 83.

Jacob H. Peisker, Hardin, who graduated at Barnes Medical College, St. Louis, in 1910, died in September, aged 70.

Winifred A. Y. Robb*, Danville, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1901, died July 24, aged 85.

Joseph Shanks*, Chicago, who graduated at the College of Medicine and Surgery, Chicago, in 1910, died September 21, aged 67.

John P. J. Shore*, Sailor Springs, who graduated at Barnes Medical College, St. Louis, in 1903, died in August, aged 78.

Louis H. Stern*, Chicago, who graduated at the University of Illinois College of Medicine in 1916, died October 6, aged 64. He was a member of the staff of the Chicago Community Hospital.

Joseph C. Urkov*, Chicago, who graduated at Chicago College of Medicine and Surgery in 1914, died October 8, aged 64. He was at one time chief of the plastic surgery division of the American Hospital.

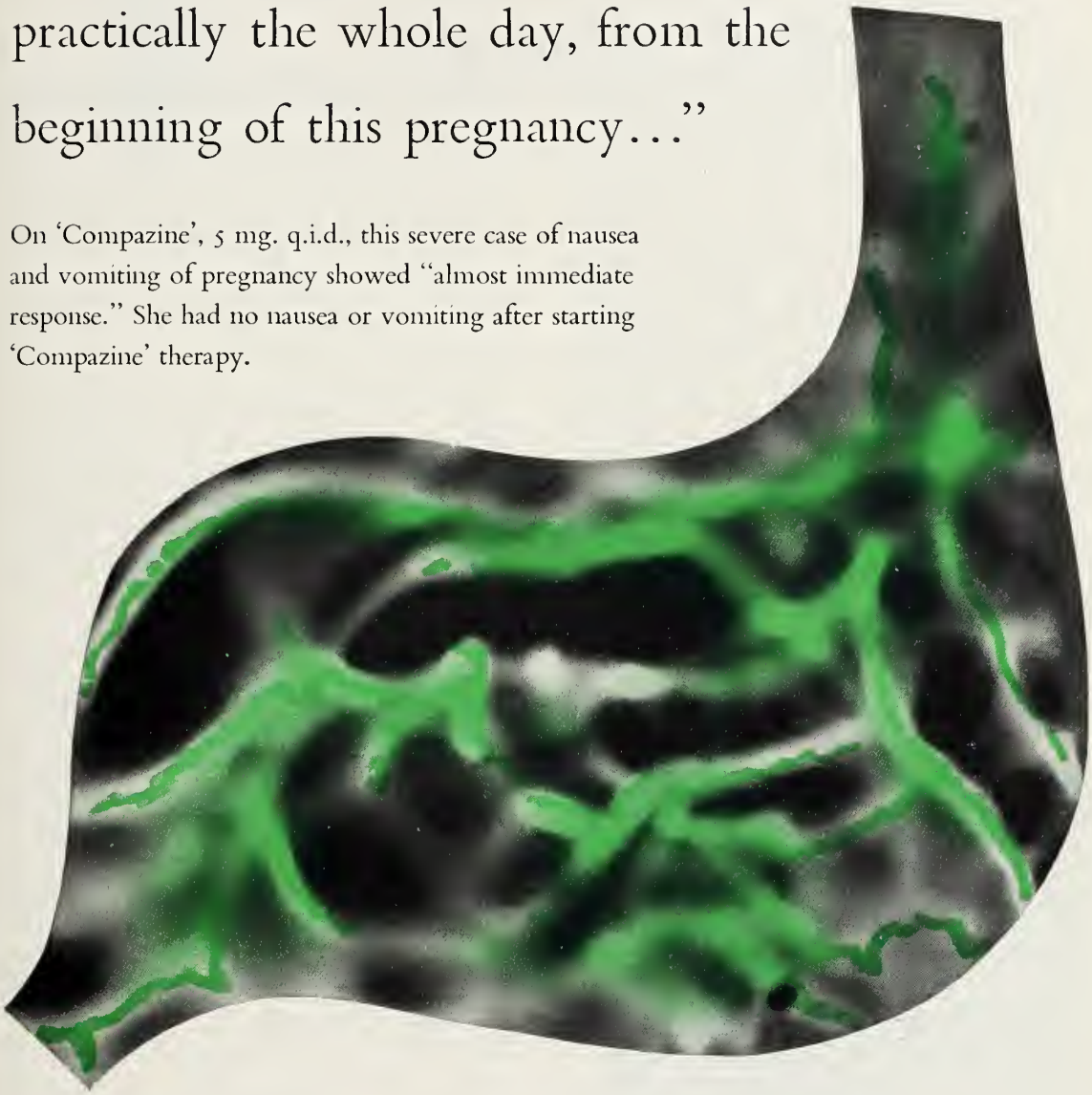
Henry L. Wenner*, Elgin, who graduated at the University of Michigan Medical School, Ann Arbor, in 1914, died September 21, aged 69.

Joseph M. Zingher*, Jacksonville, formerly of Rushville, who graduated at the Chicago Medical School in 1949, died in August, aged 37.

*Indicates member of the Illinois State Medical Society.

"...nauseated and vomiting every day, practically the whole day, from the beginning of this pregnancy..."

On 'Compazine', 5 mg. q.i.d., this severe case of nausea and vomiting of pregnancy showed "almost immediate response." She had no nausea or vomiting after starting 'Compazine' therapy.



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WOMAN'S AUXILIARY



How many workers for health?

Recently, it was reported that employment was at an all time peak. Some 68 million persons were at work. High schools and colleges are graduating every year more millions who enter the labor marts and statistics (as if we needed any) clearly indicate our birth rate is at an all time high. Yet with all this backlog of potential workers there is now, and every indication points to a continuation of, a shortage of workers available for the skilled and semi-professional crafts. The need for nurses is self-evident to the medical profession. The need for workers in the 156 other health services which provide interesting and lucrative careers is just as pressing even if not so evident.

Until recently doctors, hospitals and employers in these other health services have let nature take its course in supplying the need. We were operating in the economy of abundance theory. There were few positions available and a wealth of material seeking careers. Even though it took a period of several years of training to produce competent workers, there was always a supply. Today, however, the various industries and professions are in open competition seeking recruits. National advertising campaigns of large proportions advise us of the need for teachers in our schools and colleges. By every means of mass media the public is being advised of the necessity of increasing salaries to attract our youngsters to take up academic careers. Industry is raiding the technicians of our armed forces which has resulted in Congressional consideration of means to induce our officer and enlisted personnel to make the military a permanent career.

These truisms are cited only to emphasize the importance of the work which could be done by the Recruitment Committee of the Woman's Auxiliaries to the County Medical Societies. Our auxiliaries have organized clubs in the schools and are continuing in this effort. A vocational guidance teacher or the school nurse is the adviser and after the club is going nicely, most auxiliary sponsors step back and let the high school adviser and members carry on. We have found that students want it to be their club and their knowing that we are at hand for any assistance and advice makes it an active club.

Some of the clubs assign projects to members for which they are rated by points and achievement of the required number of points wins for the students an attractive pin. These pins usually are given by the medical auxiliaries, the sponsoring group, whose special contributions after the club is organized are to act as assistant to the adviser, helping the club make contacts in the community, planning transportation for field trips, being chaperones at parties, and being available to aid whatever projects are developed. The auxiliaries' active interest can do much to give the clubs a feeling

(*Continued on page 62*)

Current Concepts in

Feeding Newborns

Successful infant feeding depends on effective planning of the newborn's nutritional regimen. The first feeding, 12 hours after birth, may consist of a prelacteal solution of KARO® Syrup. This should be offered in one or two ounce amounts at two hour intervals for 24 to 48 hours to fulfill the high water requirement during the first week of life. Breast feeding may be initiated on the second day for five minute intervals to obtain colostrum and stimulate breast secretion. However, the prelacteal feeding is continued thereafter and between nursings.

Artificial feeding is offered on the second day if breast feeding is denied. Small infants are fed at three hour intervals and large infants at four hour intervals. The initial formula usually is a low caloric milk mixture to enable gradual adaptation of the feeding to the infant's tolerance. Concentration of the formula is gradually increased at intervals of several days, in the absence of digestive disturbances. The infant should be fed in a semi-reclining position, burped during and after feeding, and kept on his right side or abdomen undisturbed for an hour.

The same problems of infant feeding recur from generation to generation, but solutions may differ with each era. The carbohydrate requirement for all infants is as completely fulfilled by KARO Syrup today as a generation ago. Whatever the type of milk adapted to the individual infant, KARO Syrup may be added confidently because it is a balanced mixture of low molecular weight sugars, readily miscible, well tolerated, palliative, hypoallergenic, resistant to fermentation in the intestine, easily digestible, readily absorbed and non-laxative. It is readily available in all food stores.

Rx FIRST FORMULAS FOR NEWBORNS ADAPTED ACCORDING TO TOLERANCE

FORMULA I .....11 cols./oz.
*Whole Milk ..... 8 oz.
Water .....12 oz.
Koro .....½ oz.
3½ oz. x 6 q 4h.

FORMULA I .....12.5 cols./oz.
**Evop. milk ..... 4 oz.
Water .....14 oz.
Koro .....½ oz.
3½ oz. x 6 q 4h.

FORMULA I .....11 cols./oz.
Dried milk .....4 tbsp.
Water .....20 oz.
Koro .....½ oz.
3½ oz. x 6 q 4h.

FORMULA III .....16 cols./oz.
Whole milk .....10 oz.
Water .....10 oz.
Koro ..... 1 oz.
3½ oz. x 6 q 4h.

FORMULA III .....20 cols./oz.
Evop. milk ..... 6 oz.
Water .....12 oz.
Koro ..... 1 oz.
3 oz. x 6 q 4h.

FORMULA III .....18 cols./oz.
Dried milk .....6 tbsp.
Water .....20 oz.
Koro ..... 1 oz.
3½ oz. x 6 q 4h.

FORMULA II .....13.5 cols./oz.
Whole milk ..... 9 oz.
Water .....11 oz.
Koro .....¾ oz.
3½ oz. x 6 q 4h.

FORMULA II .....16 cols./oz.
Evop. milk ..... 5 oz.
Water .....13 oz.
Koro .....¾ oz.
3 oz. x 6 q 4h.

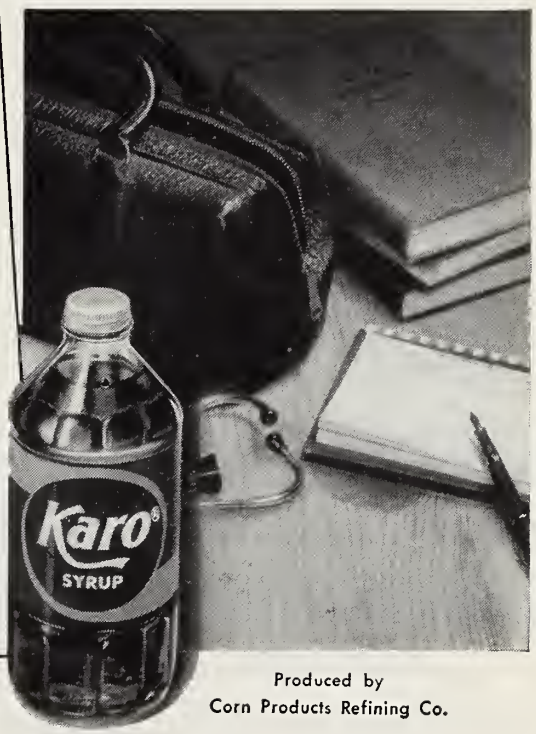
FORMULA II .....14.5 cols./oz.
Dried milk .....5 tbsp.
Water .....20 oz.
Koro .....¾ oz.
3½ oz. x 6 q 4h.

*Whole loctic ocid milk formulos may olso be prepored from whole cow's milk.

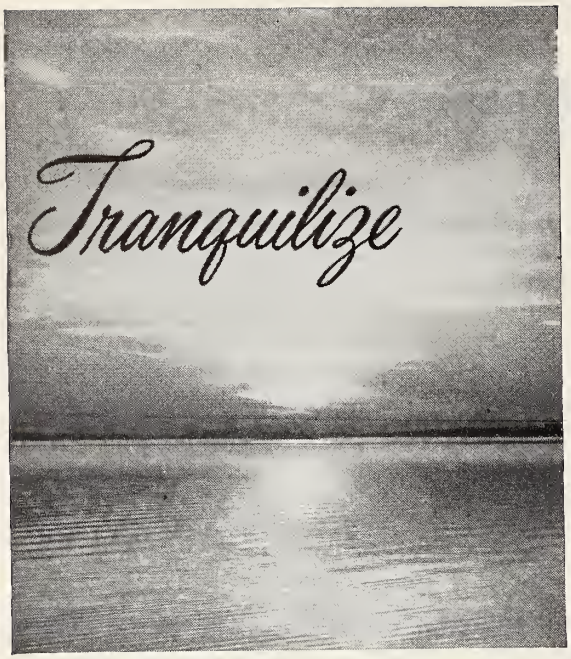
**Whole loctic ocid milk formulos moy olso be prepored from evoporated cow's milk.

Adapted from Nelson's Pediatrics, Saunders, Phila. 1954

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ACETYLCARBROMAL TABLETS

- Proved safe and effective by 6 years' clinical use.
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- Non-toxic, non-cumulative, non-addicting, no known contraindications.
- Does not impair mental or physical function.
- Orally effective within 30 minutes for sustained action up to 6 hours.
- Economical.

Indications: Tension, nervousness, anxiety and muscular spasm.

Supplied: White round tablets Acetylcarbromal 5 gr. in bottles of 100, 1000.

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WOMAN'S AUXILIARY (Continued)

of community support.

The pins to which I refer, are given to students who work at a project, giving at least 10 hours gratis. If under 16 years of age, they work in the local Red Cross office, with the American Cancer Society, or at the Rehabilitation Center. If 16 or over, the students work in the hospitals delivering mail, transporting wheel chair patients, serving trays, helping in feeding the elderly, reading to patients, and entertaining children. Their youth and exuberance are of great therapeutic value to the ill or elderly.

At this writing, an important element needed to make our work a success is the enthusiastic support of every physician in Illinois. Through them we can best be placed in contact with the schools which desire the formation of Health Career Clubs. For this purpose we can secure interesting films to be shown the students and complete instructions to the adviser of the club. Along with the doctor, we need even more the doctor's wife to do the "ground work" in organizing the clubs and in keeping them going.

Your Chairman will welcome inquiries.

Mrs. Charles L. Wunsch, recruitment chairman, Woman's Auxiliary to the Illinois State Medical Society, 1219 Downer Place, Aurora, Illinois.

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What is a treasurer? Why have one?

WHY? Because the income, tangible and intangible, that physicians receive from the people is a trust. As doctors' wives we share in the responsibility of the use of that trust. To be more effective in assuming such responsibility we must combine our individual strength. This is possible by being members of the Auxiliary whose first objective is to assist the Illinois State Medical Society in its program for the advancement of medicine, public health, and medical education. In this manner we can best serve the people who place such great trust in our physicians.

Without organization the atom cannot have the great potential power of the atomic age. Without organization the member cannot have the great potential power of the Auxiliary. To maintain organization, we must have dues so that our dollars can do the many things we cannot do and give the many services we cannot give ourselves. Yes, our talents and our dol-

(*Continued on page* 64)

In Arthritic-Rheumatic Disorders

CHECK THE ADVANTAGES OF

ATARAXOID®

the original tranquilizer-corticoid

prednisolone and hydroxyzine — ATARAX® (hydroxyzine) plus STERANE® (prednisolone)

	OVER **prednisolone alone** (or other corticoids)	OVER **corticoid-salicylate combinations**	OVER **other corticoid-tranquilizer combinations**
Emotional Stabilization	...ATARAXOID includes control of fear, anxiety	...ATARAXOID includes control of fear, anxiety	...only ATARAXOID provides the unique, specific, consistently effective tranquilizer, ATARAX
Clinical Control	...tranquilization enhances prednisolone effect for superior improvement	...tranquilization eases muscle tension (relieving aching and stiffness) precludes anxiety induced flare-ups ...enhanced corticoid control frequently superior	...tranquilizer enhancing effect is more consistent ...established by outstanding results in 94% of 919 cases*
Dosage Levels	...corticoid requirements are frequently reduced by 25-50%	...corticoid maintenance levels compare favorably; often lower	...tranquilizer dosage levels are the lowest ...more consistent tranquilization often permits lower corticoid dosage
Toleration	...corticoid side effects are significantly reduced or eliminated	...no salicylate side effects ...reduced corticoid side effects compare favorably	...tranquilizer control is the safest — and free of mental "fogging" ...reduction of corticoid complications more consistent
Patient Management	...tranquilization greatly facilitates cooperation	...tranquilization greatly facilitates cooperation	...more consistent, uncomplicated tranquilization means better cooperation

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scored green tablets, 5.0 mg. prednisolone and 10 mg. hydroxyzine hydrochloride; bottles of 30 and 100

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scored blue tablets, 2.5 mg. prednisolone and 10 mg. hydroxyzine hydrochloride; bottles of 30 and 100

Ataraxoid 1.0
scored orchid tablets, 1.0 mg. prednisolone and 10 mg. hydroxyzine hydrochloride; bottles of 100

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WOMAN'S AUXILIARY (Continued)

lars have great power. Let us use this power to preserve the values that help, guide, and enrich the lives of our fellow men.

For effective organization the need for a treasurer was recognized before money was coined and such person was delegated to guard many forms of treasure. Today our treasurer (county, state, or national) is one we have chosen as trustworthy and we have given her the responsibility of receiving, guarding, and disbursing our money for the causes our membership has decided upon. The treasurer's records must be concise, accurate, and understandable. To help each treasurer perform her task in a business-like manner, a sheet of directions is sent to her along with a packet of supplies, including (1) membership record sheets, (2) remittance sheets, and (3) membership cards. In Illinois our new Constitution and By-Laws states:

Constitution, Article V—Fiscal Year

Section 1. The fiscal year of each affiliated County Auxiliary shall be from March 1 through the last day of February.

Section 2. The fiscal year of the State Auxiliary shall be from March 15 through March 14.

By-Laws, Article II, Organization and Dues

Section 4. Each County Auxiliary shall pay annual dues to the State Auxiliary at the rate of $3.00 per capita, of which $1.00 shall go to the National Auxiliary and $1.00 to the Benevolence Fund.

Along with efficiency and responsibility, our treasurer must have a deep conviction of the values of the work that her bookkeeping helps make possible, and she must be willing to serve with the enthusiasm of one dedicated to a purpose. To avoid discord and embarrassment she needs a sense of humor, humility, and patience to correct the many innocent mistakes made and to further the understanding of all transactions. She will not get lost in the machinery of organization so she will always co-operate as a member.

As members, let us keep our perspective and see our work in relation to the whole Auxiliary so that we can make the greatest contribution possible toward the welfare of mankind.

Mrs. Wendell Roller, Treasurer, Woman's Auxiliary to the Illinois State Medical Society.

ANALGESICS AND STEROIDS:

Requirements usually reduced or eliminated.

Dosage: Aralen is cumulative in action and requires four to twelve weeks of administration before therapeutic effects become apparent. The usual adult dose is 250 mg. daily. If side effects appear withdraw Aralen for several days until they subside. Reinstate treatment with 125 mg. daily and, if well tolerated, increase to 250 mg.

If medication is withdrawn, a relapse, if it occurs, will usually be manifest within 3 to 12 months. Resumption of therapy, as above, is generally again effective.

Supplied:

Aralen phosphate: 250 mg. tablets in bottles of 100 and 1000.
125 mg. tablets in bottles of 100.

Write for booklet discussing clinical experience, tolerance, precautions, etc., in detail.

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BOOK REVIEWS



Clinical Toxicology of Commercial Products — Acute Poisoning (Home and Farm) by Marion N. Gleason, Robert E. Gosselin, M.D., Ph.D., and Harold C. Hodge, Phy.D., D.Sc. Williams and Wilkins, Baltimore, 1957. 1160 pp. $16.00.

In preparing this fine volume, the authors have listed more than 15,000 products that may be ingested accidentally or with suicidal intent. The names and addresses of all manufacturers of products described are listed in the index. In its preparation the authors have collaborated with 4,500 manufacturers.

Thousands of products used on the farm, in industry, and in the home can cause disabilities or even death, if ingested by human beings. Many do not list the contents or give sufficient warning of the hazards on the labels. The danger to infants and young children is even greater than to adults.

The book is divided into seven sections: first aid and emergency treatment, ingredients index, therapeutic index, supportive treatment, trade name index, general formulations, and the names and addresses of manufacturers. It is difficult to treat the victim of accidental poisoning without knowing the toxic contents of the preparation. The volume will be invaluable to the physician called in an emergency to treat a patient, usually a child, who has ingested one of these products — currently estimated to be 250,000 or more in the home, on the farm, or in industry. This book may become an additional incentive to all manufacturers to print on the label the precautions and contents of the product.

The reviewer, after looking over this book carefully, would urge all physicians in both urban and rural areas to keep it handy for ready reference. The first, second, and fifth sections are printed on colored paper, making it easier to find the desired information quickly. The authors and their collaborating team from the University of Rochester are to be congratulated for completing a herculean task.

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Cytologic Technics for Office and Clinic by H. E. Nieburgs, M. D., Director, Cytology Laboratory, Beth El Hospital; Research Associate, Mount Sinai Hospital; Consultant and Lecturer, Division of Cancer Control, Department of Health, New York City. Grune & Stratton, Inc. New York and London. 223 pp. $7.75. C. P. B.

The author attempts to "evaluate briefly the more important cytologic procedures" and advises on the methods of choice.

The factors involved in the cytologic aspect of pathology are legion; that is, many steps are necessary before the cell itself can be studied. The methods used for collection of the specimen are numerous and each makes some difference in the appearance of the cells in the stained preparations. For example, malignant cells in gastric washings differ greatly from those obtained by surface abrasions. The method of preserva-

(*Continued on page* 74)



One DONNAGESIC Extentab gives 10 to 12 hours of steady, high-level codeine analgesia. Rebuilding of effective analgesia with repeated doses is avoided. Patient comfort is continuous.

There is more pain relief in DONNAGESIC Extentabs than in codeine alone — codeine analgesia is potentiated by the phenobarbital present. In addition, phenobarbital diminishes anxiety, lowering patient's reactivity to pain.

DONNAGESIC is safer, too, for codeine side effects are minimized by the peripheral action of the belladonna alkaloids.

extended action—The intensity of effects smoothly sustained all-day or all-night by each DONNAGESIC Extentab is equivalent to, or greater than, the maximum which would be provided by q. 4h. administration of one-third the active ingredients.

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extended action tablets of CODEINE with DONNATAL®

once and for all every 10-12 hours codeine uses

	DONNAGESIC No. 1 (pink)	DONNAGESIC No. 2 (red)
CODEINE Phosphate	48.6 mg. (¾ gr.)	97.2 mg. (1½ gr.)
Hyoscyamine Sulfate	0.3111 mg.	0.3111 mg.
Atropine Sulfate	0.0582 mg.	0.0582 mg.
Hyoscine Hydrobromide	0.0195 mg.	0.0195 mg.
Phenobarbital	48.6 mg. (¾ gr.)	48.6 mg. (¾ gr.)

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*Reg. U. S. Pat. Off., Pat. applied for.

tion of the specimen causes a wide variation in the appearance of the finished product. Another factor is the manner of preparation; an initially satisfactory specimen may be made entirely inadequate for interpretation unless done properly.

The understanding of malignant changes has been greatly enhanced by exfoliative cytology. Especially designed instruments for obtaining cells from surface abrasion and distant body cavities have made it possible to obtain cells for microscopic study that have not yet undergone alterations causing or preceeding exfoliation. Thus, earlier changes on the affected cells are becoming known and earlier diagnosis can be made.

The foreward says the author is prepared "to describe concisely all steps from collection to microscopic examination." The microscopic interpretation of specimens has been included in each chapter.

DERMATOLOGY, by Donald M. Pillsbury, M.A., M.D., Professor and Director of Department of Dermatology, University of Pennsylvania School of Medicine; Director, Commission on Cutaneous Diseases, Armed Forces Epidemiological Board; Walter B. Shelley, M.D., Ph.D., Associate Professor of Dermatology, University of Pennsylvania School of Medicine; Chief of Dermatology Clinic, Hospital of the University of Pennsylvania; and Albert M. Kligmen, M.D., Ph.D., Associate Professor of Dermatology, University of Pennsylvania School of Medicine; Associate Professor of Dermatology, University of Pennsylvania Graduate School of Medicine. The W. B. Saunders Company, Philadelphia, London, 1956, pp. 1331, with 564 Illustrations. $20.00

Here is an excellent new work in the field of dermatology which should serve the student, the general practitioner, or the specialist. Lengthy terminology has been kept to a minimum and that which is used is of a descriptive nature.

The first four sections deal with anatomy,

(*Continued on page 76*)

when anxiety and tension "erupts" in the G. I. tract...

IN ILEITIS



PATHIBAMATE*

Meprobamate with PATHILON® Lederle

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BOOK REVIEWS (Continued)

physiology, allergy, and basic principles of diagnosis and therapy. The fifth section, which covers three quarters of the book, discusses specific skin diseases and their therapy.

The readable style of presentation is the quality that will interest many. In addition, it is one of the most complete of recent works in the field. G. W. C.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

SURGICAL TECHNIQUE AND PRINCIPLES OF OPERATIVE SURGERY: By A. V. Partipilo, M.D., F.A.C.S., Clinical Professor of Surgery, The Stritch School of Medicine of Loyola University; Senior Attending Surgeon, Columbus and St. Mary's Hospitals; Attending Surgeon and Chief of Surgical Staff, Mother Cabrini Hospital, Chicago. For students, interns, residents and surgeons. 6th edition. $20.00. Lea & Febiger, Washington Square, Philadelphia 6, Pa.

MANUAL OF NUTRITION: First published in 1945, originally the work of Dr. Magnus Pyke, a member of the Scientific Adviser's Division of the Ministry of Food. Fourth edition prepared by present members of the Scientific Adviser's Division (Food) of the Ministry of Agriculture, Fisheries and Food. $3.50. Philosophical Library, New York.

THE CHRONICALLY ILL: By Joseph Fox, Ph.D. $3.95. Philosophical Library, Inc., New York.

FADS AND FALLACIES IN THE NAME OF SCIENCE (formerly published under the title of "In the Name of Science"). By Martin Gardner. Second revised edition. Paperbound, $1.50. Dover Publications, Inc., New York.

SMOKING AND CANCER—A DOCTOR'S REPORT: By Alton Ochsner, M.D., President, American College of Surgeons, 1951-1952; President, American Cancer Society, 1949-1950; President, American Association for Thoracic Surgery, 1947-1948. Julian Messner, Inc., New York, $1.00.

HEADACHE—DIAGNOSIS AND TREATMENT: By Robert E. Ryan, B.S., M.D., M.S. (in Otolaryngology), F.A.C.S. Second edition. The C. V. Mosby Company, St. Louis. $6.75.

ONE SURGEON'S PRACTICE: By Frederick Christopher, M.D., Emeritus Professor of Surgery, Northwestern University Medical School. 151 pages. W. B. Saunders Company, Philadelphia and London. $4.00.

OBESITY; Its Cause, Classification, and Care. By E. Philip Gelvin, M.D., and Thomas H. McGavack, M.D. Price $3.50. Hoeber-Harper, New York.



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1. Gruber, C. M., Jr.: J.A.M.A., *164:* 966 (June 29), 1957.

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Hereditary aspect of Hodgkin's syndrome

In this familial study of 440 carefully verified cases of Hodgkin's syndrome, there were 15 families in which proved multiple cases of Hodgkin's disease or other lymphomata developed in blood relatives with or without direct contact, and in some instances with an interval of some years between. There were six additional families with presumptive multiple intrafamilial incidence. Although a husband and wife developed Hodgkin's disease at the same time, the clinical evidence for the disease's being transmissible directly is slight and the experimental evidence in the literature is inconclusive. The epidemiology of the disease under such circumstances, with the etiology unknown, is difficult of determination, due to the probable multiplicity of healthy carriers for every active case in which an infectious agent is involved. The statistical data do not support either dominant or recessive gene factors as influencing incidence and expressivity of Hodgkin's disease. The evidence does suggest that in some families the reticuloendothelial system may be more susceptible than in others to as yet undetermined and unidentified environmental factors which may precipitate the development of lymphomata. *John W. DeVore, M.D. and Charles A. Doan, M.D. Studies in Hodgkin's Syndrome. Ann. Int. Med. August* 1957

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Alcoholics beware!

Cirrhosis of the liver has long been a fairly common chronic disease of adult life and, with the marked reduction in mortality from infectious diseases, has emerged as one of the 10 leading causes of death in the United States. In fact, at ages 45-64, the only diseases that outrank cirrhosis of the liver as causes of death are heart disease, cancer, and cerebral hemorrhage. In 1956, the disease accounted for a total of about 18,000 deaths in our country: about two-thirds of them were among males. Nationwide morbidity data for the disease are lacking but a recent study in New York showed that it accounted for nearly 2½ per cent of all cases of hospitalized chronic disease. *Cirrhosis of the Liver: A Leading Cause of Death. Statist. Bull. Metrop. Life Insur. Co. June* 1957.

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Pernicious groupitis

We seem to have a pernicious groupitis—we have lost confidence in the strength and power and example of the individual. This seems particularly noticeable in the home training of children. Beginning as early as 2, children are sent into groups to learn things that parents could and probably should be teaching them at home. Because a child doesn't eat well, he is sent to a nursery school to learn to eat with other children. Whenever certain parents want something accomplished, they look to groups to do the job. When some behavior problem gets out of hand, the church, school, or scout group is asked to take over the work for its correction. A high school teacher friend wrote me recently that she was facing her tenth year of helping to chaperon a Hallowe'en party to keep the youngsters off the streets. She said the parents were always too busy with their own parties to help supervise or chaperon their children on such occasions. Perhaps groupitis comes from the inability of education to precede and to keep up with the action programs. Somehow, somewhere, mother has decided it is easier to buy enriched marshmallows than to make vegetables tasty, and she has not learned that this is not an even trade. Groupitis contributes to our susceptibility to faddism. It works like the facetious definition of a committee: A group of persons who individually can do nothing and collectively decide that nothing can be done. *Ruth M. Leverton. Distorting Facts into Fads. J. Am. Diet. A. Aug.* 1957.

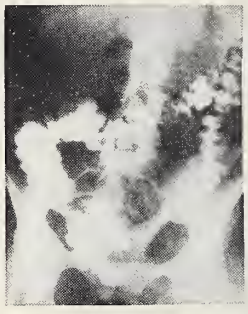
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when anxiety and tension "erupts" in the G. I. tract...

in spastic and irritable colon



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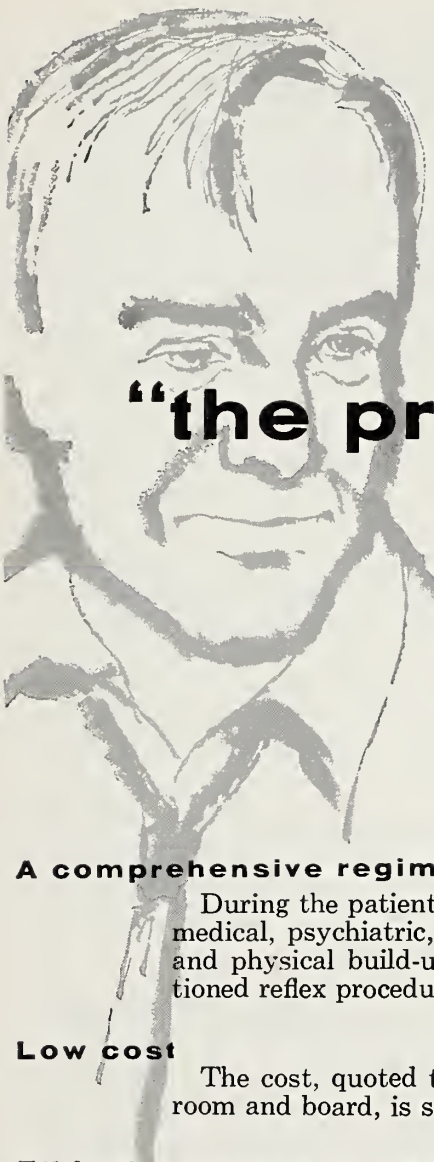
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Some physicians and dentists are recommending self-hypnosis unqualifiedly. A few have given posthypnotic suggestions to their hypnotized patients so that when, for instance, they develop headache, they can hypnotize themselves and thereby be rid of them. Maryland patients had been utilizing suggestions of this type for the development of overt schizophrenic symptoms. One was a physician. The use of repeated self-hypnosis, whatever the rationalization advanced, frequently proves to be based on a desire to further fantasy formation. There is little in the whole field of psychodynamics, in our opinion, with so great a potential for harm. At the present stage of medical knowledge, self-hypnosis can with safety be recommended only after psychiatric consultation, so that psychiatric clearance for it is obtained. It should not otherwise be suggested. If the physician himself makes use of self-hypnosis, it would be best for him to cease hypnotizing patients. Or, if he be hypnosis-reincarnation minded and feels convinced he has regressed patients to previous lives, he should under no circumstances be using hypnotic techniques; he is either himself psychiatrically ill or completely unaware of what he is handling. *Harold Rosen. Hypnosis and Self-Hypnosis in Medical Practice. Maryland M.J. June* 1957.

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Degenerative changes in obesity

It is possible that the factors concerned with degenerative changes found concomitantly with obesity are those of nutritional imbalance. Excess calories, excess fat, and excess carbohydrates can create these imbalances in the presence of an apparently adequate intake of protein and accessory food factors. Atherosclerosis is considered to be a result of these excesses and a deficiency of the sulfur amino acid, methionine. A genetic weakness of metabolism, especially of fat, may be a predisposing condition. Such a genetic weakness and dietary imbalance may be present without obesity. Similarly, excess calories, fat, and carbohydrates may be compensated by a genetic strength and sufficient intake of vitamins and proteins to overcome imbalance. This is apparently the case with the healthy, obese, geriatric patient. *Julius Pomeranze, M.D. Obesity as a Health Factor in Geriatric Patients. Geriatrics. August,* 1957.

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Finch, J. W.: Orphenadrine (Disipal) in Skeletal Muscle Disorders. To be published.

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Food for thought

I was thumbing through an old book the other day—the diary of a former mayor of New York named Philip Hone. At that time—125 years ago—a ship of immigrants had brought cholera into Quebec and it had spread along the seaboard. Hone's diary records that nine cases of cholera had broken out in New York and eight of the victims had died. The city was terror stricken. And then there was this entry in the diary: "July 5, 1832. The devil is in the doctors again. Whenever cases occur in which the public requires union, confidence, and good temper, the members of that factious profession are sure to fall out among themselves and the public health is sacrificed to the support of theoretical opinions. The Medical Society has been at issue with the Board of Health." Back in Philip Hone's time, the only reason the doctors didn't fall out with science writers was that there weren't any science writers. *Basil O'Connor, President, National Foundation for Infantile Paralysis. (Lasker Awards Luncheon, May* 1, 1957.)

Goitrogenic substances in food

The more recent literature on the production of goiter by various foodstuffs is briefly reviewed. Rutabaga and turnip are the only edible plants from which an active goitrogen has so far been isolated. The active anti-thyroid agent in these vegetables has been identified as goitrin. It is present in the plant and in the seeds of most Brassicae, as progoitrin, an inactive compound. Goitrin is apparently liberated from progoitrin only through specific enzymatic hydrolysis by a thioglycosidase contained in the plant or seed. Cooking destroys this enzyme and thus negates its goitrogenic potency by preventing the liberation of goitrin from progoitrin. Although the ingestion of considerable quantities of goitrongenic foods may contribute to the development of goiter under certain circumstances, it is difficult to incriminate them as an etiologic factor in the vast majority of goitrous patients. *Monte A. Greer, M.D. Goitrogenic Substances in Food. Amer. J. Clin. Nutrition. July-Aug.* 1957.

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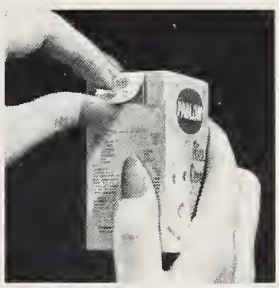
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Is extensive surgery justified?

It is the intention of this paper on carcinoma of the sigmoid and rectum to attempt to stimulate our thinking on this disease and to re-evaluate the various methods of treatment which have been evolved. In the past few years there has been a general trend toward extending the scope of operations and removing more and more tissue in the hope that a greater number of cures could be obtained. We have arrived at a point now, where, if we are going to extend further our operations for this particular affliction, we are going to have to do something of the magnitude of amputation at the waist. Operations that have been done by Brunschweig and his group eliminate from the pelvis all of the structures that can be sacrificed without sacrificing the bony pelvis and its associated structures. It will be interesting to see what the long term survivals are going to be on a procedure of this type. From the early published figures, it begins to look as though the survival rates will not be significantly higher than the survivals from the conventional type operations. In a recent report, Brunschweig et al. quoted an operative mortality of approximately 20 per cent, which is about three or four times the accepted mortality for the conventional operations for cancer of this region. One wonders whether the greater salvage rate of such extensive surgery would be justified in view of this rather high surgical mortality rate. *Charles A. Neumeister, M.D. Carcinoma of the Rectum and Sigmoid Colon. Minnesota Med. May.* 1957,

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Macular colobomata

Macular colobomata may be associated with maldevelopment of the hands and feet, which is not altogether surprising when we recall that biologically, for all its intricate specialized construction, the eye is merely the homologue of those tentacles which protrude in a series from segmented amphibians. *James H. Doggart, M. D. Macular Lesions in Everyday Practice. Lancet. Aug.* 3, 1957.

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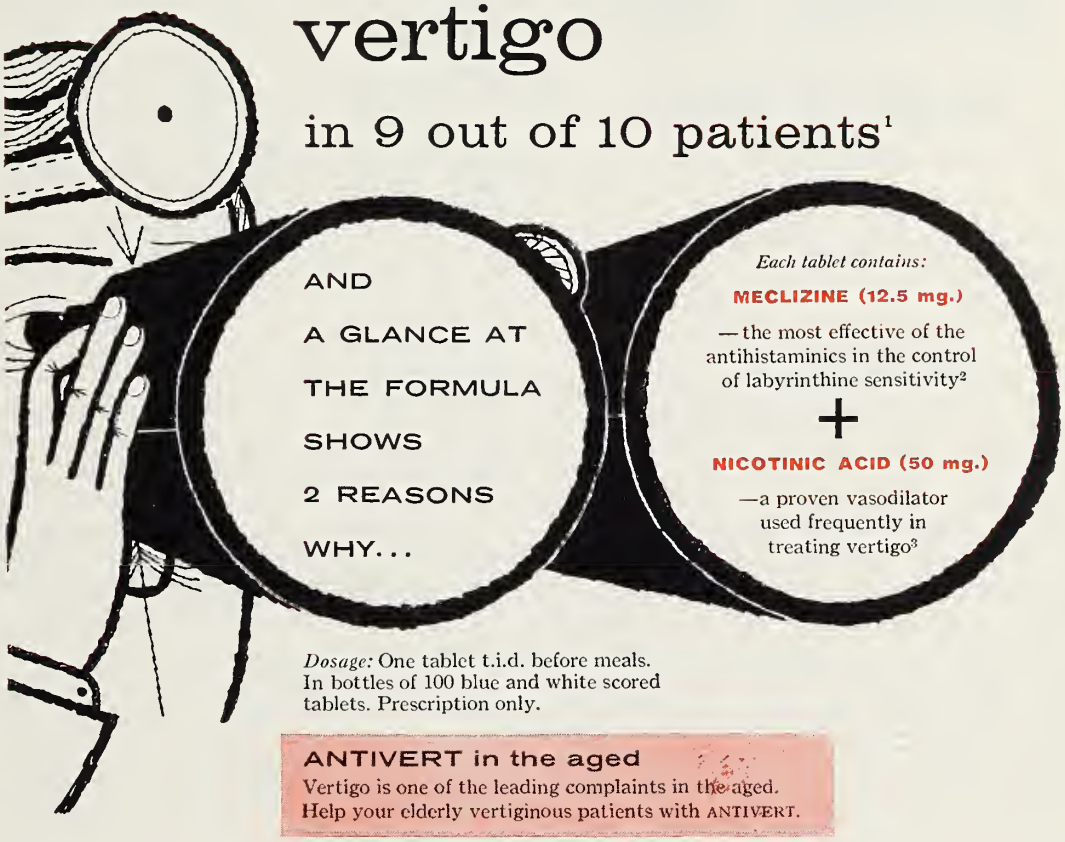
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References: 1. Menger, H. C.: Clin. Med. *4*:313 (March) 1957. 2. Charles, C. M.: Geriatrics *2*:110 (March) 1956. 3. Shuster, B. H.: Med. Clin. of N. Amer. *40*:1787 (Nov.) 1956.

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The Month in Washington



Washington, D.C.—Just how much money does the federal government spend on health programs and just how is it spent?

The answers are not easy to come by, but each year the Washington Office of the American Medical Association gathers together all of the bits and pieces of information needed to explain where and how the U.S. is involved in medicine, from cancer research to treating workmen's sniffles. Some of the material comes directly from appropriation bills, but where programs and projects are not identified there, the responsible government officials are consulted for the breakdown.

For all health and medical purposes, the U.S. during the current fiscal year is spending approximately two and one-half billion dollars. This—despite months of economy talk in the administration and in Congress earlier in the year—is about the same figure as last year.

The survey also unearthed some interesting sidelights that show perhaps more graphically than the dollar marks the extent to which federal medical activities are spreading among almost all agencies and departments.

At least 23 U.S. cabinet departments and independent agencies are engaged in some medical operations, and there are at least 79 separate health-medical activities worthy of listing and describing. Many of these in turn are responsible for scores and scores of individual operations.

This year the relatively new Department of Health, Education and Welfare tops the list of all departments in health-medical spending with $849,394,800, bounding past Veterans Administration and Defense Department, which up to now have been at the head of the column. VA is spending $849,374,000, within $20,000 of HEW, but Defense Department this year drops back more than $80 million, to $702,000,000, largely because the decreasing size of the armed forces means fewer uniformed men and dependents to care for.

Next comes the Atomic Energy Commission, but its medical spending of $40 million—mostly for research—is far down the column from the Big Three.

International Cooperation Administration has $37 million to help our friends overseas to raise their medical standards. The other 19 departments and agencies have substantially less, the last item being the $12,145 allocated to the physician entrusted with keeping members of Congress as healthy as possible.

For the first time the AMA report compiles information on the programs in which the U.S. participates for payments because of disability. Among those receiving these payments are veterans, disabled beneficiaries under social security, disabled railroad workers, etc.

Because this money is not all federal and comes from several tax sources—OASI and railroad payroll deductions as well as general U.S. revenue—it is not added to other federal medical costs in the AMA study. For the current fiscal year the total of these "payments for disability" is about $3.2 billion.

NOTES

Federal Trade Commission and Food and Drug Administration joined together to warn drug manufacturers against using "false and

(*Continued on page* 33)

WASHINGTON (Continued)

misleading claims" to promote drug products for use against Asian influenza. It was pointed out that vaccine is the only protection, and that a physician is needed if there are complications.

Meeting at the invitation of the Children's Bureau, a group of specialists in the health fields discussed use of X-rays of the newborn and pregnant women and concluded that restraint must be exercised.

There has been remarkable progress in the last five years in the fight against tuberculosis, but there are still at least 250,000 active cases in the United States. This is the gist of a special nationwide survey by Public Health Service and the National Tuberculosis Association.

While visiting Russian women scientists were telling of a 25-cent drug to treat Asian influenza, it was learned that some members of the Russian Embassy staff in Washington had been vaccinated with American vaccine.

In a major address, President Eisenhower pleaded for more private financial aid to medical colleges and warned against the dangers of federal controls in this field.

When asked his opinion on legislation for the hospitalization of the aged under social security, Secretary Folsom warned against the tax increase that would have to accompany the plan, possibly a suggestion that the administration will oppose the idea next year as it did last.

Reversing a previous policy, the Internal Revenue Service now says it is possible for a group of doctors to practice as an "association," thereby qualifying for approximately the same tax benefits they would receive under the proposed Jenkins-Keogh law.

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About five years ago, Dr. Norwood of South Carolina called the attention of the profession to the fact the veratrum viride was eminently an arterial sedative. *Boston M. & S. J. July* 30, 1875. [New England Medical Journal]

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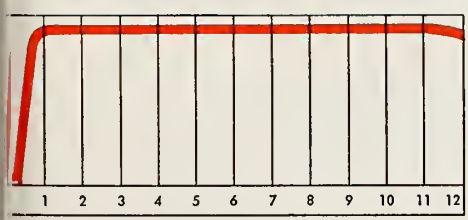
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Recurrence of mumps

It is not uncommon for patients with mumps to give a history of a previous attack. Enders has found that supposed second attacks take place in 4 per cent of cases, but he doubts whether these are all instances of infection with mumps virus. Recurrence of parotid swelling, even during a single outbreak, has been reported. One French soldier is said to have had six attacks in five months, and two buglers had three relapses each. (Ogilvie has reported parotid swelling in a bugler due to air in the glands.) Recurrent parotid swelling seems to be associated usually with either allergy or infection, especially Streptococcus viridans, with or without obstruction of the duct. The introduction of mumps virus into Stensen's duct of an immune monkey may cause swelling of the gland within 72 hours, and this has been noted in man. This type of allergy is uncommon, the only effect of reinfection usually being a rise in antibody. Howlett et al. have now reported parotitis associated with herpangina on the palate and pharyngeal wall, and serological investigations ruled out mumps infection. As Coxsackie viruses also can give rise to meningoencephalitis and orchitis, it seems that infection with them can simulate mumps. With the present improved facilities for the diagnosis of virus diseases, investigation of recurrent or sporadic "mumps" might yield interesting results. *Editorial. Recurrent Parotid Swelling. Lancet. Sept.* 21, 1957.

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Tuberculosis prophylaxis

Prophylaxis in tuberculosis has become a highly controversial subject. Some enthusiasts advocate widespread use of isoniazid in highly exposed population groups. Others are equally firm in their conviction that such use of isoniazid would have grave consequences by interfering with the development of natural immunity. But there also is a middle ground, one occupied by many physicians and public health workers. They feel, as does the Public Health Service, that only a series of large, long-term, controlled investigations can provide actual data to replace the present spate of conjecture on the effects of using isoniazid to prevent clinical tuberculosis in human beings. *Shirley H. Ferebee and Frank W. Mount, M.D. Pub. Health Rep. May* 1957.

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DECEMBER, 1957
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Adenoviruses

George Gee Jackson, M.D., Chicago

THE history of periods of sharp increase in our knowledge about viruses has been very closely related to three general aspects of virology. One is the development of new laboratory techniques for working with viruses; another, is the discovery and observation of previously unrecognized susceptible hosts; and the third is clinical epidemiology. The story of the adenoviruses is an interesting and important one in these respects. In vitro, tissue culture techniques were the basic tools required for definitive identification and classification of adenoviruses; however, clinical epidemiology, antedated our knowledge of the viral agents. Another concept derived from this recent work and one that might be as important as the recognition of adenoviruses *per se* is the use of autogenous tissue cultures for the "unmasking" of latent disease producing viruses within cells.

RECOGNITION OF THE ADENOVIRUSES

I would like to review briefly the story of the recognition of the adenoviruses. To do so one needs to refer to the terms: Febrile Catarrh, Acute Undifferentiated Respiratory Disease of Recruits (ARD), RI Agents, Adenoid Degenerative Agents, and Adeno-Pharyngeal-Conjunctival or APC viruses.

In 1938 Stuart-Harris, Andrewes and Smith[1] in England described a syndrome of respiratory infection with fever which was insidious in onset and in which sore throat and cough were more prominent than accompanied infection with the influenza virus. The authors labelled this "febrile catarrh." Subsequently catarrhal fever, or "cat fever" in the vernacular of the military, was recognized as a common malady among military personnel, especially among recruits.

During World War II the members of the commission on Acute Respiratory Diseases of the Army Epidemiologic Board[2-5] carried out a series of studies carefully designed to establish suitable criteria for classifying the common forms of respiratory diseases of military importance. They described a similar febrile respiratory infection of short duration with constitutional and pharyngeal symptoms that differed from the clinical picture of the common cold or influenza virus infection, but which was non-bacterial in origin and occurred in regular epidemics during the winter months without significant variation in the clinical illness from one year to another. This illness was referred to as Undifferentiated Acute Respiratory Disease of Recruits, or ARD. The results of human transmission studies established the etiologic

Presented before the 17th Annual Conference of the Illinois Public Health Association, April 24, 1957.

From Research and Educational Hospitals and The Department of Medicine, University of Illinois College of Medicine Chicago, Illinois.

identity of ARD and its immunologic difference from the common cold and primary atypical pneumonia of the type associated with cold agglutinins.[6-7]

In 1952-3 Hilleman *et al.*[8] studied an epidemic of respiratory disease at Fort Leonard Wood, Missouri, and recovered from the throat washings of patients with clinical primary atypical pneumonia, a viral agent that was cytopathogenic for human adult tracheal epithelium in tissue culture. The new agent was referred to as RI-67. Four additional cultures of virus were obtained from the same epidemic, two from the throat washings of patients who had clinically typical ARD. Complement fixing antibody against RI-67 was demonstrable in the sera of these patients and comparative serologic studies with paired sera from patients with other types of respiratory diseases were negative.

At the same time Rowe, Huebner and coworkers[9,10] at the NIH were propagating tissue explants of human adenoids that were placed in plasma clots and cultured in roller tubes. The cultures usually grew well during the first week with epithelial and fibroplastic outgrowth. During the second and third weeks, however, characteristic degeneration of the epithelial cells occurred in 62 per cent of the adenoids that were observed. The culture fluid from 14 of these degenerated adenoids was transferred to new non-degenerating adenoid tissue cultures and in all except one instance, degeneration of the fresh culture was produced. Subsequent passages proved that the agents recovered from human adenoids were cytopathogenic for epithelial cells from a wide variety of human and animal sources.[11,12] The technique was referred to as "unmasking" viruses because the same tissues did not yield virus when they were macerated and placed directly on a fresh culture.

The adenoid degenerative agents and the RI agents were subsequently observed to belong to the same family of viruses now referred to as the adenoviruses of which there are at least 14 types of human origin and 18 strains of simian origin.

PROPERTIES OF THE ADENOVIRUSES

The adenoviruses are cytopathogenic for the human epithelial carcinoma cell, strain HeLa in tissue culture. The absorption of virus upon HeLa cells is rather slow and incomplete after several hours; then there is a lag period of nearly 24 hours before appreciable multiplication of virus occurs. Although the entire sheet of cells usually shows certain cytologic changes, not all of the cells become infected. The rapidity with which the cells round up and slough is dependent in part on the maintenance medium, especially the amount and kind of serum present, the pH, the amount of glucose in the medium, and some other factors.

The *infected* cells in a culture undergo certain characteristic changes in addition to rounding-up and clumping. The cytoplasm at the periphery of the cell remains clear but the nuclei become enlarged and granular. Supravital staining has revealed that in contrast to poliomyelitis and some other cytotoxic viruses, adenoviruses do not necessarily produce death of the cell. Actually some proliferative changes occur as manifested by increased utilization of glucose and increased production of lactic acid. Although the virus multiplies rapidly in infected cells it is not readily released from the cells into the supernatant culture. There are, however, soluble complement fixing antigens present in large amounts in the culture medium. These are group specific antigens rather than type specific, although recent evidence indicates that the CF antigens from the various types of adenovirus are not identical.[13]

Some essential properties of the adenoviruses have been recorded by investigators at the NIH.[11] The viruses are primarily epitheliotropic, they infect cells of normal human epithelium as well as the human cervical cancer cells, monkey kidney, and rabbit trachea. They are not pathogenic for laboratory animals. The viruses are not denatured by ether and are relatively stable at room temperature; they are readily inactivated at 56°C. The common antibiotics do not inhibit the infectivity of the viruses. The soluble antigens that are group specific antigens give rise to complement fixing antibodies and other antigens that stimulate type-specific neutralizing antibodies.

Biophysical studies have indicated that the size of the virus particles is 30-120 millmicrons with calculated density of about 1:1[14,15]

One of the striking and important features of the adenoviruses is that they are localized almost exclusively in the nucleus of cells at least until

the late stages of cellular infection. Thus they are not only intracellular but also intranuclear viruses. Electron photomicrographs have been published by Kjellen[16] and co-workers and by Hartford.[15] They show the virus particles within the nucleus lined up in rows in what is called a "crystal-like array." Indeed recent cytologic observations suggest that some virus is present within the cell in crystalline form. By the use of cytochemical techniques it has been shown that these crystals contain some DNA.[17] Studies with labelled antibody demonstrated that the virus is localized in the nucleus until late in the infection. Then it may appear in abundance in the cytoplasm.[18] Even after the cell layer has completely sloughed 90 per cent of the virus, it is still intracellular.

CLINICAL EPIDEMIOLOGY OF ADENOVIRUSES

The clinical syndromes that seem reasonably well established as resulting from infection with one or another of the adenoviruses include: Acute respiratory disease of recruits (ARD) with types 3, 4, and 7, pharyngoconjunctival fever and swimming pool conjunctivitis caused predominantly by type 3; nonbacterial exudative pharyngitis; acute bronchitis; and primary atypical pneumonia without cold agglutinins from types 3, 4, or 7. Types 1, 2, and 5 probably cause some respiratory illness among infants and have produced respiratory illness among adult volunteers who are free of antibody in the prechallenge serum.[19] The agent identified as type 8 adenovirus has been associated either by virus recovery or serologically with most of the cases of keratoconjunctivitis that have been studied recently.[20] At present, the relationship of some of the other adenoviruses to clinical illness is less clear and there is still considerable knowledge to be gained in this area.

In a survey of a civilian population in Washington, D. C., Heubner and associates[11] obtained evidence for wide dissemination of infection with adenoviruses. Within the first year of life more than one-half of the population develops antibodies to one or more of the adenoviruses and over one-half of adults have neutralizing antibodies against 3 types.

This widespread distribution of adenoviruses raises the questions of their relative importance in common respiratory illnesses, the frequency of inapparent infections and the basis for differences in susceptibility. Among military recruits, according to the studies of Hilleman[21] and associates, approximately 90 per cent showed evidence of infection with type 3, 4, or 7 within a few months after induction. Of these, one-quarter were hospitalized because of acute respiratory infection; one-quarter were treated for respiratory infection at the dispensary; and one-half reported no illness. Among college students living in dormitories and among civilian family groups, evidence of infection occurs in less than 20 per cent and accounts for less than 5 per cent of respiratory illness among the latter groups.[22,23,24] One paradox is the rarity of type 4 infections among civilian populations and its frequency among military recruits.

The resistance of individuals is related to the serum titer of neutralizing antibodies but not to complement fixing antibody. Among susceptible persons without antibodies the frequency of infection is related to age and other factors, but data suggest that about 1 in 8 susceptible adults acquire infection upon contact with the illness and about 1 and 2 susceptible children.

From the epidemiologic studies of Bell and associates[25] the incubation period during natural infection was estimated to be 6-9 days in the majority of cases. Ninety per cent of these cases of epidemic illness had fever; two-thirds had conjunctivitis and/or pharyngitis; and 20 per cent had the three symptoms.

Type 8 adenovirus deserves special mention for it is the only one of the agents that has been shown to cause keratoconjunctivitis which is an interstitial inflammation of the cornea. This is in contrast to the conjunctivitis that occurs with pharyngoconjunctival fever which is a transient and benign inflammation of the conjunctiva only. Serologic evidence of contact with type 8 adenovirus has been found for very few persons except those with keratoconjunctivitis.[20]

IMMUNIZATION

Since type-specific neutralizing antibody protects the person from infection the question of the immunization of populations that have high attack rates is logical. Several pilot studies have now been performed among military recruits regarding the antigenicity and efficacy of a formalin killed vaccine grown on monkey kidney cells.[26,27,28] The published data from Hilleman

and his group with regard to the immunogenic reaction among volunteers given a single injection or 2 injections of bivalent types 4-7 vaccine showed that neutralizing antibody for the homotypic strains appeared or increased with rare exception. In addition, heterotypic antibody for type 3 was also stimulated.

The effectiveness of the vaccine in the prevention of respiratory disease among recruits has been determined in field trial.[28] Its effectiveness in the prevention of illness with adenovirus was almost complete 2 weeks after immunization.

SUMMARY

The application of tissue culture techniques and the concept of "unmasking" latent viruses have enabled the identification and classification of a new family of viruses with the generic name of adenoviruses. This has validated and clarified certain epidemiologic observations with regard to some common respiratory and ocular illnesses that are frequent among military personnel and occur to a lesser extent among civilians. The viruses are epitheliotropic, intranuclear agents which produce group-specific soluble complement-fixing antigens, and are neutralized by type-specific antibody. Formalin killed virus is immunogenic and will prevent infections among a population with a high spontaneous attack rate. The desirability of general use of the vaccine is undetermined.

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Clinical Observations With an Oral Nasal Decongestant

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MORE lost time from industry and schools results from the symptoms of the common cold than from all other diseases combined, with an estimated annual loss of 5 billion dollars[1,2]. Unfortunately, intensive research has not provided effective methods for the prevention of this disorder. Therefore, it is important to make the patient as comfortable as possible until his own body defenses are able to inactivate the causative organisms.

One of the usual procedures in the treatment of the symptoms of the common cold is the local application of vasoconstrictors. This, however, has its shortcomings and disadvantages. Very often, the topical medication is poorly distributed and the copious mucous blanket present during a cold does not allow for satisfactory local absorption. The indiscriminate use of nose drops, sprays and inhalants may result in undesirable nasal mucosal pathology such as paralysis of cilia, damage to the nasal mucosa, and chronic nasal congestion[3]. Also, the effect of a local vasoconstrictor in the nose is very temporary and, in some instances, continued use leads to rebound turgescence[4,5]. Thus, an oral type of medication is both desirable and advantageous because it insures better distribution to the mucous membranes and minimizes the hazards of tissue changes.

Clinical observations indicate that the common cold begins with a vasodilatation and hyperemia of the mucous membranes of the nose, throat, larynx, or trachea. Lewis[6] has shown that stimulation of the skin by many and various agents gives rise to the liberation of H-substance, which is considered to be histamine. Since there is a relationship between the mucous membranes of the respiratory tract and the epidermis, it is hypothesized that in acute colds, the primary pathological phenomenon of vasodilatation may be due to the liberation of histamine[7].

In approaching the problem of controlling the changes which occur during the common cold, consideration must be given to the administration of orally active histamine antagonists, as well as orally active agents which will cause decongestion.

The use of a combination of antihistaminics has been reported to broaden the therapeutic spectrum and decrease the intensity of side actions[8,9,10,11,12].

Pheniramine maleate and pyrilamine maleate are two orally effective and well-tolerated histamine antagonists which are logical selections for combination therapy of this type.

Ephedrine is a well-established agent as a vasoconstrictor, decongestant and bronchodilator following oral administration. However, in many patients, it produces anxiety, nervousness, and insomnia[13]. Phenylpropanolamine acts similarly to ephedrine, but its effect is more prolonged and it is less likely to produce central stimulation[14]. Therefore, the oral use of phenylpropanolamine would contribute significantly to the control of the symptoms of the common cold and nasal allergy.

MATERIAL AND METHODS

Preliminary clinical studies were conducted, using the double blindfold technique, with the following formulations in capsules:

	Formulation A	Formulation B	Formulation C
Phenylpropanolamine HCl	Placebo	25 mg.	25 mg.
Pyrilamine maleate		15 mg.	20 mg.
Prophenpyridamine maleate (Pheniramine maleate)		15 mg.	20 mg.
Phenyltoloxamine dihydrocitrate		15 mg.	20 mg.

The oral dosage was 3 to 4 capsules per day — at breakfast, noontime, midafternoon and, in some instances, before retiring. Seventy three (73) patients suffering from nasal symptoms associated with the common cold, nasal allergy, and postnasal discharge received the medication. A total of 81 observations was made.

Based on the results obtained in the preliminary study, a second evaluation was carried out using a "timed release" oral tablet* with a slightly modified formulation — 50 mg. phenylpropanolamine HCl; 25 mg. pyrilamine maleate, and 25 mg. pheniramine maleate. The total amount of each ingredient is divided equally between a core and a compressed coating in the concentrically constructed tablet. The coating disintegrates rapidly to give 3 to 4 hour action; then the core disintegrates after 3 to 4 hours, giving an additional 3 to 4 hours of pharmacological effect. The dosage usually employed was 1 tablet t.i.d., at breakfast, midafternoon, and before retiring. Therapy was continued until the nasal symptoms subsided.

Two hundred seventy (270) patients suffering from nasal symptoms associated with the common cold, nasal allergy, and postnasal discharge were studied and the results reported. In this second study, the double blindfold technique was not employed.

In both instances, the criteria used for measuring the clinical response to the medication were determined by the reports from the patients.

*Triaminic (Smith-Dorsey)

RESULTS

The results of the double blindfold study are shown in Table 1.

Table 2, shows the side actions encountered.

It may be seen that Formulation "B" had 16.1 per cent failures while Formulation "C" had 12.9 per cent failures. However, Formulation "B" also showed a higher percentage of *Good* responses than did Formulation "C", but the significance of such difference is open to question. With Formulation "A" (placebo), there were 42.1 per cent failures. Although only 19 observations were made in the entire series with placebo, Formulation "A", it is interesting to note the relatively high percentage of *Good* and *Fair* responses.

Table 3 shows the results obtained with the "timed release" tablets. In addition to the results shown in Table 3, 25 patients with allergic

Table 1.
Preliminary Evaluation (Double Blindfold Technique) of Combinations of Antihistamines Plus a Sympathomimetic Administered Orally in Capsule Form for the Treatment of Nasal Symptoms

Response	Formulation A		Formulation B		Formulation C	
	No. of Patients	%	No. of Patients	%	No. of Patients	%
Good (Better than previous medication, or marked improvement)	5	26.3	19	61.3	16	51.6
Fair (Same as previous medication, or improvement)	6	31.6	7	22.6	11	35.5
Poor (Worse than previous medication, or no improvement)	8	42.1	5	16.1	4	12.9
	19	100.0	31	100.0	31	100.0

Table 2.
Side Actions Encountered with Combinations of Antihistamines Plus a Sympathomimetic Administered Orally in Capsule Form For the Treatment of Nasal Symptoms

	Formulation A	Formulation B	Formulation C
None	19	23	22
Some dizziness	0	1	1
Drowsiness	0	3	2
Eyes water — hay fever worse	0	1	0
Eyes swollen and itchy	0	1	0
Nervousness	0	0	2
Warm sensation	0	2	0
Slight lightheadedness	0	0	1
Dry throat	0	0	1
Drowsiness and upset stomach	0	0	1
Tingling of fingertips	0	0	1
Total:			
No side actions	19	23	22
Side actions	0	8	9
	19	31	31

rhinitis obtained good relief with 1 tablet 3 times a day. Eight (8) patients with chronic postnasal discharge also were benefited by taking 1 tablet at bedtime, as were 2 patients on 1 tablet every 8 hours.

Side actions were encountered infrequently. When they did occur, they consisted of insomnia in some patients and drowsiness in others. The usual precautions were observed in patients known to be sensitive to sympathomimetics and antihistaminics. For the most part, the drowsiness produced by the depressant effects of antihistamines was pharmacologically balanced by the mild central nervous system stimulating action of the sympathomimetic.

The failure rate shown in Table 3 is approximately the same as that shown for Formulations "B" and "C" in Table 1, i.e., 12.3 per cent, 16.1 per cent, and 12.9 per cent respectively. This is of considerable interest, since the results in Table 1 were obtained with the double blindfold technique, whereas that method was not employed in obtaining the results shown in Table 3. Table 3 also indicates a relationship between dosage and response: The 61 patients taking 1 tablet every 4 waking hours, or approxi-

Table 3.
Clinical Effectiveness of Triaminic "Timed Release" Tablets in the Treatment of the Nasal Symptoms Associated with Upper Respiratory Disorders

		Results (Symptomatic Relief)							
		Marked or Excellent		Moderate or Good		Poor		Totals	
Dose	Symptoms	No. of Patients	%	No. of Patients	%	No. of Patients	%	No. of Patients	%
1 tablet t.i.d.[15]	Coryza rhinitis, rhinorrhea	65	37.4	82	47.1	27	15.5	174	100.0
1 tablet every 4 waking hours[15]	Coryza rhinitis, rhinorrhea	53	86.9	6	9.8	2	3.3	61	100.0
Totals		118	50.2	88	37.5	29	12.3	235	100.0

mately 4 tablets per day, showed a failure rate of 3.3 per cent in contrast to a failure rate of 15.5 per cent in patients taking 3 tablets per day. The relationship between dosage and response is also emphasized in the *Marked or Excellent Response* group where approximately 4 tablets per day provided marked or excellent response in 86.9 per cent of patients, and 1 tablet t.i.d. provided marked or excellent response in 37.4 per cent of the patients.

DISCUSSION

These results indicate that a combination of antihistamines plus a sympathomimetic is effective in controlling nasal symptoms associated with certain upper respiratory disorders. Walsh[4] has also reported that orally administered phenylpropanolamine HCl, as well as phenylpropanolamine HCl plus an antihistamine, provides relief of nasal congestion.

Besides avoiding the risk of nasal mucosal pathology associated with topical application, the oral administration of decongestants provides better distribution via the blood stream, and furnishes decongestion in areas that cannot be reached by topical administration[5]. Oral administration also provides longer duration of action. Post-therapeutic turgescence or "rebound" is rarely encountered[5].

It should be borne in mind that Triaminic does not attack the cause of the disease. It is directed toward relieving the symptoms which are caused by vasodilatation, inflammation and hypersecretion of the mucous membranes.

SUMMARY

Clinical results indicate that in a high percentage of patients, the Triaminic formulation provides an effective oral treatment for the control of nasal symptoms associated with upper respiratory disorders, including coryza, rhinitis, and rhinorrhea.

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The Evolution of Pathology in Chicago

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THE present level of the practice of pathology in Chicago has been reached during the last century. A review of the evolution of this specialty in our medical practice discloses that the study of pathology began in a group of clinicians who were interested in pathological tissues, usually obtained by postmortems. Several years ago the late Doctor Louis E. Schmidt gave me Volume I of the Chicago Medical Register and Directory, edited and published in 1872 by Doctors T. Davis Fitch and Norman Bridge. The signature of his father, Ernst C. Schmidt, is written in ink across the fly leaf of this volume and he had contributed significantly in its publication. The volume, in pages devoted to the history of medical societies, records that proposals for establishing a medical society in Chicago were made during the assembly of physicians at Springfield in 1850 when the Illinois State Medical Society was organized.

At a meeting later a Chicago Medical Society was formed and R. D. Boone was chosen president for the year 1851. The Society prospered for a few months but before the first half-year had passed, a member used abusive language toward the president and was expelled. W. B. Herrick was elected president at the annual meeting of this Society in April 1851 but the attendance at subsequent meetings was below the quorum necessary for the transaction of business. This situation continued until the Annual Meeting April 5, 1852 when a motion to adjourn *sine die* dissolved the original Chicago Medical Society. Immediately N. S. Davis, E. McArthur, W. B. Herrick, H. A. Johnson, and D. B. Palmer resolved themselves into a new Society, the Cook County Medical Society. The growth of this Society was rapid and the meetings were well attended. Six years later, in 1858, the name of the Cook County Medical Society was changed to the Chicago Medical Society. At the time of the Chicago Fire in 1871, the Chicago Medical Society had an estimated membership of about 80.

After the great fire in October 1871, the Chicago Medical Society established itself on the West Side of the city. A group of clinicians in this Society was interested in the study of pathological tissues, usually obtained by necropsy examinations. About April 10, 1878 when the Chicago Medical Society moved to the South Side of the city, a nucleus of the West Side group became the West Chicago Medical Society and continued to foster this interest in pathology. Three years later, in 1881, at the suggestion of Dr. H. M. Lyman, then the president of this society, the name was changed to the Chicago Pathological Society. According to the Constitution then formulated "the object of the Society shall be the cultivation of the Science and Art of Medicine with special reference to Pathology and Morbid Anatomy." The officers for the year 1882-83 were H. M. Lyman, president; H. Webster Jones, vice-president, and Robert S. Hall, secretary-treasurer. Pursuant to the objectives originally stated, the Chicago Pathological Society has continued now through 76 years, and the interest in pathology which began in this small group of physicians on the West Side spread into the medical schools of Chicago, Rush Medical College first and then into the others.

Interest in pathology had existed in Chicago before the organization of the Chicago Pathological Society in 1881. Nathan S. Davis a founding member of the Cook County Medical Society (1817 to 1904), according to Ludvig Hektoen's review on "Early Pathology in Chicago and Christain Fenger," came to Chicago in 1849 as professor of physiology and pathology at Rush Medical College and was the first to hold this chair in Chicago. He brought a microscope, believed to be the first one to be used in this city.

From the Henry Baird Favill Laboratory of St. Luke's Hospital, Chicago, Ill.

The earliest record of a necropsy in Chicago found by Hektoen is by Daniel Brainerd in 1844 describing an anencephalic with a cardiac malformation, and in the same year Austin Flint reported two instances of sudden death "with autopsical examinations." At the staff meeting of Cook County Hospital on December 30, 1865, Henry M. Lyman who later became the first president of the Chicago Pathological Society, was appointed to the newly created position of pathologist or "curator of the dead house." Lyman had small facilities for his assignment, a knife, a saw, a chisel and a mallet, and the attending physicians, choosing to make dissections themselves on their deceased patients, left little for the curator in an institution without a microscope, and unable to afford alcohol and jars for specimens. Lyman in 1870 was succeeded by Hosmer A. Johnson.

Shortly after November 1873, the office of the pathologist at Cook County Hospital was abolished by the medical staff but in March 1877 the staff, recognizing a neglect, decided again to appoint a curator and I. N. Danforth was appointed. Ludvig Hektoen stated that of the three physicians mentioned, only Isaac N. Danforth (1835-1911) merits the designation of pathologist. In fact, he regarded Danforth the only pathologist worthy of this name before Christian Fenger. Danforth initiated the practice of demonstrating postmortem examinations to classes of medical students. Before receiving his appointment as pathologist at Cook County Hospital on March 28, 1877, he had been pathologist at St. Luke's Hospital for some time, but in that institution the autopsies were few, were generally made hastily, surreptitiously, and never in the presence of students. At that time there were no laws or other means for obtaining a division of anatomic material and every professor of anatomy and every demonstrator became a pirate, who prowled in the dead houses of hospitals in search of material. An upheaval in the staff of the County Hospital during the spring or summer of 1878 blew apart the Medical Board and forced the dismissal of the pathologist.

The work of Danforth, however, prepared the background for Christian Fenger who in the years 1877 to 1902 stimulated pathology profoundly and advanced the entire practice of medicine in Chicago. His appointment at Cook County Hospital began in the spring of 1878, first as pathologist and later as surgeon. Then followed the splendid growth of pathology in Chicago under L. Hektoen, E. R. LeCount, H. Gideon Wells, Robert Zeit, R. H. Jaffe, D. J. Davis, J. P. Simonds and others which has carried into the generation of pathologists now active in Chicago.

A review of the titles of papers presented at the meetings of the Chicago Pathological Society during the seventy-six years of its life discloses 1) that reports of scientific studies in medicine, foremost in pathology, are dominant, and 2) that through this wealth of pathologic material of human diseases are reports of experimental studies in bacteriology, immunology, serology, biochemistry, hematology, and physiology. About the turn of the century (1900), cases of blastomycetic dermatitis and systemic blastomycosis were studied intensely by Ricketts, LeCount, Wells, Montgomery, and others. Reports on bacteriological studies began to appear in the programs about this time. Howard T. Ricketts, October 14, 1907, reported on the "present status of Rocky Mountain spotted fever" and on February 8, 1909 on the "demonstration of a bacillus specifically associated with Rocky Mountain fever." This was a bipolar staining bacillus about the size of an influenza bacillus. The similarity of the pathology and symptoms of typhus fever to those of Rocky Mountain spotted fever prompted Ricketts to go to Mexico City and there examine the blood of patients with typhus for the presence of organisms similar to those he had seen in spotted fever. In the midst of this endeavor, he was stricken with typhus and died, but not before he had demonstrated organisms now known as the Rickettsia bodies, and which are in the group of diseases now designated "rickettsial". His untimely death on May 3, 1910 was grievously lamented by the Society and the following "In Memoriam" appeared in the Transactions:

In Memoriam

"Dr. Howard Taylor Ricketts died in Mexico City May 3, 1910, 39 years old. His death was caused by typhus fever, in the study of which he was actively engaged when taken sick.

Dr. Ricketts advanced our knowledge of

blastomycosis; he solved the problems of the cause and transmission of Rocky Mountain spotted fever, thereby adding to our general knowledge of the part insect may play as carriers of disease; and in his last, brilliant work on typhus he seems to have reached the secret of even its cause.

With his death a noble career of large service to humanity meets an heroic end; medical science loses an investigator of the first rank, in whom the genius of discovery had taken abode and did flourish.

A man of quiet determination, modest and unassuming, earnest and genuine in all his doings, he was dear to all who knew him.

His name—our Ricketts—will live in the history of medical science and live in glory.

Resolved, that we express to his wife and family our warmest and most heartfelt sympathy."

Shortly after this time, and for several years, reports on the relation of focal infections to systemic disorders, notably infectious arthritis, by E. C. Rosenow, Frank Billings, and others appeared in the programs. Then follow studies on the influence of heredity on spontaneous tumors in mice by Maude Slye, H. G. Wells, and Harriet Holmes; and the experimental studies on chemotherapeutic agents, especially salts of metals, in tuberculosis by H. G. Wells and associates. This merged finally into the work on the isolation of the tuberculin principle in crystalline form by Esmond R. Long and Florence Seibert. Studies in anaphylaxis by H. G. Wells and his group belong in this period, and in immunology, specific precipitins and complement fixation reactions by Dr. Hektoen at the McCormick Institute of Infectious Diseases.

Papers on immunity and more recently on blood groups and experimental carcinogens have appeared on the programs. These statements do not imply that the members of the Chicago Pathological Society initiated all scientific thinking in Chicago, but they did constitute a group that fostered pathology and scientific investigations in medicine and were alert to progress in these fields in this country, in Europe, and elsewhere. This interest influenced the entire practice of medicine in Chicago.

George H. Weaver became Secretary of the Chicago Pathological Society on May 14, 1894 and served 31 years until May, 1925. His successor, the present Secretary, is serving (1957-58) his 32nd year. What two successive secretaries of any other society have compiled 63 consecutive years of service, covering in that stretch all but 13 of a total of the 76 year span of the Chicago Pathological Society. However, when secretaries of the Chicago Pathological Society become vocal over a long period of service, they should be reminded that A. A. Goldsmith in 1948 completed 41 years of continuous service as treasurer of the organization.

About forty years ago, if the conditions prevailing in Chicago are taken as representative of those in other large medical centers, the practice of surgical pathology was in its infancy. Prior to this a few of the tissues removed by surgeons were taken to the pathology departments of medical schools and the professor of pathology was approached with the statement that here was something of unusual interest to him. Had he suggested a small fee for this service, the professor would have been regarded as ungrateful of a privilege. He, of course, was most interested in pathological material obtained through his own necropsy examinations, and he had little concern for the tissues that the surgeon removed. The surgeon himself, realizing that much and sometimes significant diagnostic information was obtained by the microscopic examination of a surgically removed tissue, organized a small laboratory for preparing tissue sections. He or his assistants interpreted these preparations. Later, laboratories in hospitals took over this function and pathologists were employed to supervise the clinical laboratories, examine the tissues removed at surgery, and make the postmortem examinations. But even surgeons at this time were not fully aware of the potentials of diagnosis available to them through the microscopic examination of tissues by a pathologist. I recall an experience of about 1920 with Doctor E. C. Dudley, a prominent gynecologist of Chicago. He curetted a patient and the tissues removed were sent to the laboratory for examination, as was the established practice. The endometrial tissues were reported to him as tuberculous. Shortly thereafter Dr. Dudley came to the laboratory, reminded me of the report and after a few brief comments said, "I do not un-

derstand how you can make a diagnosis of tuberculosis without having seen the patient."

If 1922 is chosen as the beginning of the second decade of the last 40 year span, in that year the laboratory at St. Luke's Hospital examined 1,137 tissues removed at surgery and 1,272 tonsils. At that time the examination by the laboratory of all tissues removed surgically had been a routine practice for several years. These figures indicate that 52.3% of the surgical operations in that year were tonsillectomies. For the year 1932, the beginning of the third decade, the number of tissues removed at surgery was 2,667 and of tonsils 1,282. The tonsillectomies accordingly constituted 32.5% of the total surgical operations. The totals for 1942 were, respectively 4,813 and 637, and the percentage of the tonsillectomies had decreased to 11.6% of the total surgery; and in 1952 these surgical procedures numbered 7,189 and 251, with the number of tonsillectomies only 3.3% of the total surgery. These percentages of tonsillectomies indicate how the practice of surgery has shifted in this field of specialization. The popularity of other forms of surgical procedures also has changed, former practices have disappeared and new ones have been introduced or are in the testing phase. The increase in the number of tissue examinations in each of the last two decades has not resulted from the broader application of a routine practice but reflects the greater utilization of biopsy examinations in diagnosis, especially in the field of cancer, and also the development of specialized practices in surgery, notably bronchology.

All of this development of anatomic pathology and the significant contributions in this field by many Chicago physicians have occurred within a span of seventy-five years, at first through necropsies correlating disease symptoms with morbid changes in tissues and experimental studies of infectious agents; and then during the past forty years through the application of these established prineiples to the diagnosis and treatment of disease in patients, that is surgical pathology, of which today diagnostic biopsies are a large segment. The affiliated clinical pathology has increased in service functions during the past twenty-five years far beyond all expeetations in private and hospital practices.

Similar progress in general praetice and in the specialty practiees has taken place, parallel with these advances in pathology. Medicine in America is not static, and no professional has a greater opportunity for an appreciated serviee than has the doctor in his private practice and in his contributions to eommunity health.

The opportunities and the clear responsibilities of all engaged in medical instruction, research or practice in Chicago are unlimited. Chicago, one of the largest medical centers in the world, has enviable opportunities to achieve greatness in medicine. Here are five great medical schools, many outstanding hospitals, scientists and skillful physicians. The home of the parent organization, the American Medical Association, is at our doorstep. The Chicago Medical Society has contributed in large measure to all branches of medieine and continues to initiate and to motivate programs of undergraduate and postgraduate education. It will stimulate zeal for basic and clinical investigations, it will improve the quality of private practice, and it will contribute further to the advancement of civie health.

Promethazine Hydrochloride for the Control of Nausea and Vomiting During Spinal Anesthesia

A. B. Stearns, M.D. and George C. Frederickson, M.D., Detriot, Michigan

THE popularity of spinal anesthesia has decreased markedly in the past 20 years. This has been brought about by the advent of the thiobarbiturates as anesthetic agents, the use of relaxant drugs, and the overall rapid progress in the field of anesthesiology. This decrease in popularity has been universal with patient, surgeon, and anesthesiologist.

Few patients desire to be alert to their surroundings in the operating room. There is an inborn (justifiable) fear of any tampering with the central nervous system. Articles in the lay and professional press have publicized unfortunate results due to spinal anesthesia — neglecting mention of comparable hazards with other methods. The very few patients who experience really severe postpuncture headache broadcast far and wide, often echoed by members of the medical profession who do not have to stand or sit at the operating table. Seldom now is the threat of ether an influence in the patient's choice and they clamor for the quick oblivion of the thiobarbiturates, forgetting that they are ill equipped to choose.

Surgeons no longer need resort to spinal anesthesia in self-defense against poor relaxation or hazardous general anesthesia. A few inopportunely timed bouts of retching will make most surgeons forget the beautiful operating conditions provided by spinal anesthesia. Patients and anesthesiologists are equally upset.

In view of these situations the anesthesiologist has had two choices: he may give a general anesthetic or he may often be forced to supplement the spinal anesthetic to allay the patient's apprehension or to control vomiting. This universal practice of using a second complete anesthetic[1] to cover the faults of the first is both illogical and hazardous. The dangers of light thiobarbiturates and nitrous oxide or light cyclopropane anesthesia in combination with a method that predisposes to vomiting are obvious. Deeper anesthesia, often with endotracheal intubation to control the airway problems thus created, is absurd but sometimes necessary.

Numerous drugs or combinations of drugs have been tried to avoid the imposition of complete supplemental anesthesia. Heavy doses of the usual premedicants often are unpredictable; opiates and opiate substitutes often make vomiting worse and may dangerously depress respiration. Chlorpromazine[2] has proved incompatible with spinal anesthesia, due to profound and occasionally uncontrollable blood pressure drops. The barbiturates generally are difficult to control.

It has seemed unfortunate that apprehension and vomiting should create an obstacle in the use of such a basically sound method as spinal anesthesia. In searching for the answer to this problem, interest in promethazine as an antiemetic and hypnotic during spinal anesthesia was stimulated by a recent article by Sadove[3].

Promethazine is a potent, long acting antihistaminic. The early investigative work was done by Halpern.[4] This drug is one of the triad of the "lytic cocktail" — meperidine, chlorpromazine, and promethazine — devised by Laborit,[5] for use in conjunction with hypothermic anesthesia. In addition to its basic action promethazine possesses hypnotic-sedative and antiemetic side effects that are of value for the purpose of this study.

In a recent period of 10 weeks, 382 spinal anesthetics were administered and personally managed by six experienced anesthesiologists. Of this number, 138 records were found to be suitable for this study of the effects of promethazine on vomiting. No selection of cases was made and the use or non-use of promethazine was based purely on chance. All patients had received or-

dinary premedication for their age, physical status, and procedure contemplated. Ephedrine sulfate, 50-75 mg. was used as a prophylactic vasopressor. The anesthetic agent was Pontocaine® combined with 10% dextrose and either ephedrine or epinephrine in appropriate doses, (1 cc. (10 mg.) Pontocaine, 1 cc. 10% dextrose, and 1 cc. (50 mg.) ephedrine for inguinal herniorrhaphy, appendectomy, or hysterectomy.) Oxygen was administered to all patients undergoing cesarean section but to no others. Vasopressors and parenteral fluids were used as indicated.

Promethazine in 12.5 to 75 mg. total dosage was administered intravenously either before or immediately after the spinal anesthetic was given. Initial dose was based upon the apparent effectiveness of the preanesthetic medication. Subsequent doses were given as necessary to produce a level light sleep from which the patient could be easily aroused and in which all protective reflexes were preserved. Any patient receiving promethazine before vomiting was classified as a vomiter, whether hypnosis was thought to be adequate or inadequate at the time.

Usable records were found to present 44 cases receiving no promethazine and 94 cases receiving promethazine.

TABLE 1
DOSE OF PROMETHAZINE

Promethazine	No. of Cases
12.5 mg.	4
25.0 mg.	57
37.5 mg.	5
50.0 mg.	27
75.0 mg.	1

Vomiting occured in 26 of the 44 cases without promethazine, or 59.1%; and in 11 of the 94 cases receiving promethazine, or 11.7%. This would seem clinically significant at least.

TABLE 2
INCIDENCE OF VOMITING

	Cases	Vomited	% Vomiting
Without Promethazine	44	26	59.1
With Promethazine	94	11	11.7

Surgical procedures included 10 lower extremity, 37 perineal, 78 lower abdominal and 13 upper abdominal operations. Of these, those receiving promethazine numbered, lower extremity 5, perineal 17, lower abdominal 64 and upper abdominal 8.

TABLE 3

	Total Cases	Received Promethazine
Lower extremity	10	5
Perineal	37	17
Lower abdominal	78	64
Upper abdominal	13	8

In this series 77 patients fall into the 13-50 age group, 51 were 50-70, and 10 were 70-78 years old.

TABLE 4
AGE DISTRIBUTION

Age	No. of Cases
13-50	77
50-70	51
70-78	10

There probably is no more certain way to produce vomiting than the administration of spinal anesthesia for cesarean section. There were 14 such procedures in this series; seven of the nine that received promethazine did not vomit; all five without promethazine vomited. One baby from this group was slow in crying, was easily resuscitated, but yawned frequently and acted sleepy during its period of observation in the operating room, though his color was excellent. This mother had had a long trial labor and had received several doses of meperidine and scopolomine. It is believed that the promethazine should be avoided in such patients until the baby has been delivered.

The side effects have been interesting. Most gratifying was the additive action with barbiturates, opiates, and scopolomine of preanesthetic medication usually producing a tranquil cooperative patient who slept through the entire operation unless disturbed. A few patients seemed to derive more than their share of the hyocine-like action of the drug and, for this reason, the arms should always be securely restrained lest the surgeon have an uninvited assistant.

Cardiovascular effects, as shown by Howarth[6], did not seem remarkable. Two patients exhibited a moderate tachycardia which may have been a manifestation of the anticholingeric action of promethazine. Systolic blood pressure showed no deviation attributable to the drug.

Two patients in this series came to the opera-

tion room exhibiting typical morphine idiosyncrasy. They were nauseated, pale, cold, and sweating. One, who previously had had a cholecystectomy, also complained of epigastric pain. Both patients promptly received their dose of promethazine and, within five minutes, were comfortable, pink, warm, and dry.

SUMMARY

Study was made of 138 patients receiving spinal anesthesia. Promethazine hydroehloride, in doses of 12.5 mg. to 50 mg., was given intravenously immediately before or after the anesthetie to 94 of these patients; 11, or 11.7, vomited during surgery. The antiemetie effeet was marked. Of the 44 patients receiving no promethazine, 26, or 59.1%, vomited during surgery.

Psychic effect was excellent in most instances producing co-operative, sleepy patients.

There were no alarming cardiovascular changes attributable to the use of promethazine.

The only undesirable action of promethazine was an occasional exaggerated scopolomine response.

It is felt that promethazine is a valuable adjunct to spinal anesthesia from the standpoint of patient, surgeon, and anesthesiologist and will do much to eliminate the need for a second anesthetie with spinal anesthesia.

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Low fat diet for young men

Some families have a blood vessel metabolism (or is it a sieve) that can handle high fats without having deposits. Such members do not have a blood rise in cholesterol when on a high fat diet. Their arteries do not tend to form plaques. However, in the United States, 65 per cent of the young men cannot handle this national diet (with 40 per cent of more of its calories from fat) without getting severe deposits. Thus, in order to save many of our men from getting too old too soon, we must make it clear that, whatever else affects this problem, very few young men will ever show a heavy deposit in their coronary arteries if they will consume only 20 per cent or less of their calories as fat. Evidenee indicates that this factor, whieh is eontrollable, will help us to defer and possibly prevent an unpleasant and uncomfortable old age. *Walter Bortz, M.D. and Nils P. Larsen, M.D. Atherosclerosis—a Preventable Factor of Early Aging. Geriatrics. Oct.* 1957.

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Rh incompatibility

The most important praetical unsolved problem in erythroblastosis is that of intra-uterine death, particularly in the cases eaused by Rh ineompatibility. Prevention of erythroblastie stillbirth eould save about 5,000 babies a year in the United States and these are not babies carrying abnormal genes but simply the unfortunate victims of cireumstances, like persons hit by lightning. *Fred H. Allen, Jr. M.D. and Louis K. Diamond, M.D. Erythroblastosis. New England J. Med. Oct.* 3, 1957.

Virus-Cell Interrelationships

George G. Jackson, M.D., Associate Professor of Medicine, Moderator.

John E. Kempf, M.D., Professor of Bacteriology.

Max E. Rafelson, Jr., Ph.D., Associate Professor of Biological Chemistry.

Richard J. Winzler, Ph.D., Professor and Head, Department of Biological Chemistry.

Doctor Samter: Recent meetings in the East concerning relationships of viruses to the host cell were attended by several members of our department. Doctor George G. Jackson has agreed to function as moderator today in a discussion which we hope will help bring us all up to date in this rapidly advancing field.

Doctor Jackson: Virus is a word that is on the lips of many persons these days. As clinicians we speak about virus infections with considerable aplomb, but too often such a diagnosis is a kind of ignorant guess or suspicion. At the same time new families of viruses are rapidly being discovered. House officers have a limited experience with recognized viral infections because the majority of them produce a mild or an acute brief illness and the patients are rarely admitted to the hospital. Other patients are sent to separate wards for contagious diseases and still others such as those with myelitis or encephalitis may require the services of specially trained groups.

There are still many areas where our techniques and knowledge about viruses are greatly deficient, but on the other hand microbiologists, chemists and immunologists have contributed information about viruses at a tremendous rate. The virus-cell interrelationship has served as a useful model for the investigation of fundamental biologic processes and has enabled new insight into cellular metabolism and the biological properties of certain extracellular substances as well as about the nature of viruses per se.

It seems important to me for clinicians in so far as possible to keep abreast of the new knowledge which is of such basic nature and for that reason we have scheduled the seminar today on virus-cell interrelationships. We are pleased to have as our participants in the Seminar Dr. J. E. Kempf from the Department of Microbiology and Dr. Richard J. Winzler and Dr. Max E. Rafelson, Jr. from the Department of Biochemistry. I would like to ask Doctor Kempf to open the discussion with some comments about the nature of viruses, what they are, their component parts, and some of the techniques by which this knowledge has been gained. Doctor Winzler will consider biochemical factors in the invasion of the cell by the virus and Doctor Rafelson is going to discuss some changes in cellular metabolism induced by viral infection. As a preface I might say that one can still start a lively argument among well informed people as to whether viruses are living entities with their own complement of genes and therefore true mutants, or whether they are only biochemical templates that distort normal cellular metabolism to reproduce the viral particles.

Doctor Kempf: The chemical nature of viruses is quite variable. All contain nucleic acids — some ribonucleic acid (RNA) and some desoxy-ribonucleic acid (DNA). Various carbohydrates may be found bound to the nucleic acid. Influenza viruses contain viral and host protein,

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but disagreement exists as to whether this protein is actually a part of the virus or is a contaminant. Lipids comprise the membrane which encases the virus. I shall not enter the debate concerning life in these particles except to reiterate that they reproduce.

You are all familiar with photographs of viruses obtained with the election microscope. Some are cuboidal, some spherical, some rod-shaped. The phage virus is spherical with a filamentous tail.

To demonstrate the life cycle of a virus we might consider the influenza virus with which we all have a nodding acquaintance. Before this virus enters the host it attaches to a cell membrane by enzymic activity. After attachment, the virus in some way enters the cell and fractionates into component fragments. This early intracellular phase is called the eclipse phase since we cannot by present methods detect what events occur. At any rate, with maturation, the virus again forms with protein, nucleic acid, and a lipid membrane. Now the host cell membrane forms filaments which are readily detectable but the nature of which is unknown. Each filament, regardless of size, contains one infectious unit. If a filament is divided, it loses its capacity to produce infection. I should add that we know that a portion of the eclipse phase occurs within the host cell nucleus since antibodies tagged with fluorescein appear primarily within the cell nucleus.

Doctor Samter: Which antibodies do you label with fluorescein?

Doctor Kempf: We tag gamma globulin of influenza antisera.

Doctor Jackson: The adenovirus in HELA cell culture is almost all intranuclear until the advanced stages of infection and yet the cytoplasm of the cell is equally or more infectious. Is there any plausible explanation for this in terms of incomplete virus or provirus?

Doctor Kempf: Evidence points toward intranuclear production of the infective agent found in the cytoplasm.

Doctor Jackson: Would you comment on incomplete virus and on recombination of virus components to yield infectious virus?

Doctor Winzler: Perhaps I can best illustrate this by recalling that the tobacco mosaic virus can be associated into its protein and nucleic acid portions, neither of which is infective. These can be caused to recombine to produce again the infective virus. Furthermore, the protein of one strain of virus can be combined with the nucleic acid of another strain to produce infective virus. It is the nucleic acid fraction alone which determines the type of infection produced, however.

I should like to spend my remaining time discussing viruses and enzymes. For years investigators have sought to demonstrate enzymes as part of virus particles. Conclusive evidence of an enzyme activity associated with viruses has been obtained only in three instances—the presence of an ATPase in Rous chicken sarcoma virus, an enzyme in the tails of certain phages which causes hydrolysis on the wall of E. coli and an enzyme in the influenza viruses which splits off a component of the cell membrane of the cells it attacks.

This last observation grew out of the finding by Hirst in 1941 that red cells agglutinate when influenza virus is present. After a time there is dissolution of these aggregates of red cells. The erythrocytes cannot then be re-agglutinated, but the virus retains its ability to agglutinate other red cells. It is believed that the virus attaches to the erythrocyte—each virus binding two cells together. This causes agglutination. Then by enzyme activity, the virus splits off sialic (neuraminic) acid from the red cell surface and the agglutinated cells separate. It is presumably by the action of this enzyme that the virus is able to gain entry into the cells.

Doctor Jackson: Is this an amylase or a protease?

Doctor Winzler: Gottschalk calls this neuraminidase. It splits the glycosidic bond of the terminally located neuraminic acid from the next molecule (presumably a hexosamine) with which it is combined. It, therefore, can be considered a sort of glycosidase. Figure 1.

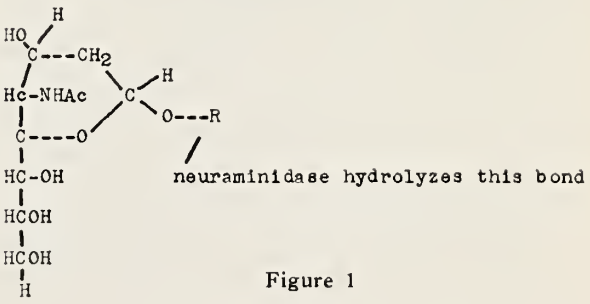


Figure 1

It is an interesting fact that a number of glycoproteins contain this terminal neuraminic acid group. Some of these are attacked by the virus enzyme and the neuraminic acid is split off just as in the cell membranes. These glycoproteins act as inhibitors of the hemagglutination caused by influenza virus—presumably by occupying the enzyme site and blocking the red cells from the enzyme. These viral hemagglutination inhibitors are present in most body fluids. Their physiological function is still unknown.

Doctor Jackson: Can these concepts be used to explain differential sensitivity of cells to infection in the same tissue?

Doctor Winzler: Undoubtedly. This differential sensitivity most likely results from differing alignment of glycoproteins in the host cell membrane—some alignments being more resistant to attachment of certain virus and more sensitive to others.

Doctor Jackson: Doctor Rafelson, what happens to the nucleic acid synthesis in an infected cell?

Doctor Rafelson: We know little about the origin of virus constituents except in the case of bacteriophage. RNA is formed by polymerization of soluble nucleotides. Virus infection stimulates RNA formation. Normally E. coli produces large amounts of RNA and very little DNA. With phage infection RNA production stops abruptly. The DNA present is presumably broken down to its nucleotides and the cell is never again able to produce its normal DNA. Rather, it produces DNA characteristic of the phage virus present.

Doctor Jackson: Unfortunately, our time is up although there still is much that could be discussed. Perhaps the best summary is to comment again upon the basic nature of the biologic phenomena associated with viral infection. This is why it is somewhat plausible to suggest viruses as the cause of almost any disease for which there is no known etiology. In closing I would like to say that at present one can find examples of viruses that cause disease, viruses for which no disease is known, diseases in which the causative virus is not known; tumors caused by viruses and virus therapy of tumors. The field is vast and young and I would predict many important contributions from it in years ahead.

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Inherited susceptibility in rheumatic heart disease

It is always wise to investigate by history and examination the relatives of persons who have or are suspected of having rheumatic heart disease, for it is to such families and not to everyone, that one should more particularly apply preventive measures. Here, heredity and environment—that is, host and agent—probably share on the average about equally. But it may well be true that in extreme cases, there may be a very high degree of inherited susceptibility with exposure to but little streptococcal infection on the one hand or heavy infection with relatively slight susceptibility on the other. Families with several members involved obviously need more protection than the community at large against the hemolytic streptococcus. *Paul D. White, M.D. Genes, the Heart, and Destiny. New England J. Med. May* 23, 1957.

Ultran as a Dermatological Tranquilizer

Fred Robert Schwartz, M.D., Chicago

MANY of the clinical entities routinely coming to the attention of the dermatologist can be directly attributed to a psychic or neurogenic origin. In an equally impressive group, the psyche may indirectly influence the course of a dermatological lesion and its response to therapy. These tenets provide for rather extensive use of established drugs with known sedative properties.

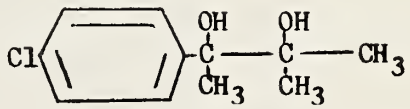
The introduction of an entirely new series of sedative drugs with unusual pharmacological and physiological properties is well known. These agents, referred to as tranquilizers, ataractics, neurosedatives, or calmatives, naturally provoked interest among dermatologists. The merits and limitations of certain of these agents have been documented. While some have failed to provide the range of therapeutic effects anticipated, most appear to have some merit, solely or in combination with the recognized regimens of the specialty.

Ultran®* has been under investigation on our service for a sufficiently long period of time to warrant the observation that it possesses therapeutic attributes considered superior to certain agents of essentially similar properties evaluated by us. The new preparation is somewhat more potent than meprobamate on a mg. per mg. basis. Unlike meprobamate, however, patients on Ultran seldom experience annoying or even incapacitating drowsiness. In this study, Ultran was utilized singly or in combination with local therapy, oral antibiotics, or steroids. The dosage ranged from 600 to 900 mg. per twenty-four hour period. The standard 300 mg. dose has been prescribed on a b.i.d. or t.i.d. basis depending upon the degree of sedation demanded in each individual case.

From the Department of Dermatology, Stritch School of Medicine, Loyola University.

*Furnished through the courtesy of Eli Lilly & Co.

Chemically, Ultran differs from other established tranquilizing or ataractic drugs. It is one of a series of butanediols synthesized by personnel of the Lilly Research Laboratories. Its full name is 2-p-chlorophenyl-3-methyl-2, 3-butanediol. The structure for Ultran is depicted as shown:



Extensive animal and clinico-pharmacological studies in humans have indicated that Ultran is a safe, potent drug even when dosages far in excess of those effective clinically are administered for long periods of time. In this investigation, toxic manifestations were absent. Extensive work in animals and humans has demonstrated that Ultran has no significant effect on blood pressure, respiration, or the electrocardiogram tracing.

Condition	Number of Cases	Dosage 300 mg.	Excellent	Good	Poor
Urticaria	3	t.i.d.	1	2	
Trichotillomania	1	t.i.d.		1	
Neurodermatitis	20	t.i.d.	7	13	
Allergic Eczematoid Dermatitis	28	t.i.d.	12	16	
Infectious Eczematoid Dermatitis	3	t.i.d.	3		
Psoriasis	6	t.i.d.	3	3	
Alopecia Areata	3	b.i.d.	2	1	
Pruritus Ani et Vulvae	6	t.i.d.	1	5	
Dermatitis Herpetiformis	1	t.i.d.		1	
Atopic Dermatitis	3	t.i.d.	1	2	
Factitial Dermatitis	6	t.i.d.	3	2	1
Otomycosis	1	t.i.d.	1		

CONCLUSION

Ultran provides a desirable combination of properties — low toxicity and low sensitization — and it reduces anxiety and tension rapidly

and effectively. It has few side affects and provides tranquilization without sedation.

Reports have appeared revealing the effectiveness and usefulness of Ultran as a tranquilizing agent. The present study concerns not only the tranquilizing properties of Ultran but also its antipruritic effect in a wide variety of conditions encountered in everyday dermatologic practice, manifesting itself effectively by reducing the itch-scratch-itch cycle. It is wise to emphasize that dermatologists are inconclusive regarding any permanent benefits derived from the use of the tranquilizing drugs, although they are considered of value in making the patient more manageable and more amenable to other forms of therapy.

720 N. Michigan Ave.

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Clinical Study: Treatment of Burns to Control Pain and Infection

George H. Hassard, M.D., Alton

All too frequently we physicians become so absorbed in the scientific aspects of handling "a case of pathology" that we lose perspective, and treat lightly the patient as an individual. Actually, from the viewpoint and understanding of the patient, fifty per cent of the cure is complete when symptoms are relieved. The gratitude of the patient, moreover, insures a rapport that enhances the success of subsequent therapy.

A person with a first or second degree burn demands relief first and foremost. This criterion for the drug of choice is more important than all others, save prevention of infection. MacGregor, Pfister, et al.[1] have listed 15 criteria for local treatment of burns, but each must be weighed for importance against every other criterion on the list.

For several years I have used an ointment containing 20% dissolved benzocaine in a bland water-soluble base for relief of painful burns, abrasions, lacerations, and other surface injuries. But my apprehension concerning infection compelled me to mix it half and half with the broadest spectrum antibiotic ointment, which I found to be neomycin. Frequently I assigned this messy task to one of the nurses, much to her consternation. One day while talking with a detail man, I protested this chore and asked why the drug company did not compound the two products for dispensing in mixed form. Obligingly, the drug company formulated such a preparation* and furnished a supply for this study. The ointment contains 20% ethyl-p-aminobenzoate (benzocaine) in dissolved form, and 5 mg. neomycin sulfate per gram, in a bland, water-soluble base.

It is known that benzocaine is practically insoluble and that it must be in solution to be effective. Actually, 4% disolved benzocaine has been the maximum concentration obtainable in a bland, non-irritating, water-soluble base. Now, by means of a special process, 20% benzocaine has been dissolved in the preparation used in this clinical investigation.

The ointment under consideration has only a local direct action. An ointment form was chosen because it penetrates deeper layers than aqueous solutions, dusting powders, or lotions, and par-

*Americaine w/Neomycin Ointment. Supplied by Arnar-Stone Laboratories, Inc., Mount Prospect, Illinois.

tially suppresses insensible perspiration and intracellular fluid accumulation which may result in maceration. The antibiotic does not deteriorate because no water is contained in the mixture. The ointment base is a series of polyethylene glycols.

The ointment used in this study meets the following criteria for the preparation of choice for local treatment of burns:

1. *Relief of Pain.* As stated above, relief of pain is the most urgent demand of the burned patient. Shock and collapse frequently are blamed on severe pain. Benzocaine has long been recognized clinically as one of the most effective agents for this purpose for topical application. Tainter studied the pain-relieving properties of about 40 different drugs and evaluated benzocaine as "the best topical anesthetic."[2] White and Madura, in a study of 132 cases of various dermatological conditions, found a 20% dissolved benzocaine ointment to be highly effective and safe, relieving 128 cases, with relief lasting up to 5 hours with a single application.[3] Finkel, Levine, and Wohl found this ointment highly effective in relieving many conditions encountered in industrial practice, such as burns, (first, second, and third degree, including X-ray burns), abrasions, lacerations, various itching dermatoses and pruritic conditions, and lesions involving loss of skin surface such as skin wounds and amputation stumps.[4] Schmitz, Smith, and Carberry found it superior in all ways to two widely used topical anesthetics for relief of post episiotomies, fissured nipples, and tender hemorrhoids.[5]

2. *Prevention of Infection.* Of all the antibiotics recommended for local application, neomycin appears to provide the widest antibacterial spectrum. Livingood[6] found it effective against hemolytic staphylococci, hemolytic streptococci, Proteus, Pseudomonas, and miscellaneous gram negative bacilli, and generally superior to oxytetracycline, chlortetracycline, chloramphenicol, bacitracin, and polymyxin B. Of clinical importance, also, is the fact that topical application of neomycin does not create sensitivity or immunity to other antibiotics, such as chloramphenicol, chlortetracycline, or oxytetracycline, should they become necessary for the patient at some future date. Livingood's[6] experience is shown below.

3. *Low Sensitivity Index.* Published studies including over 11,800 cases have not reported a single case of sensitivity to the 20% dissolved benzocaine ointment, although observations for sensitivity have consistently been made by all writers.[2,3,4,5,8] This is unusual as all topical agents of therapeutic usefulness are capable of producing reactions in a small percentage of cases. In our own experience, we have failed to notice any case of sensitivity to the benzocaine-neomycin ointment, and this observation has led us to an empiric conclusion: Although this ointment contains 20% benzocaine, the benzocaine is in dissolved form, in the carbowax vehicle. Apparently the solubility of this medium reduces the probability of sensitization. However, it would not be logical to regard it as entirely non-sensitizing. Sensitivity may be acquired from prolonged and consistent exposure to the drug. Apparently such patients are rare and are of the type who have history of allergy.

4. *Systemically Nontoxic.* Benzocaine has been determined to be one of the safest drugs in the medical armamentarium. Adriani[7], in an extensive study of the toxicity of various topical anesthetics, found benzocaine to be 1/10th as toxic as cocaine; 1/30th to 1/50th as toxic as pontocaine; and 1/50th as toxic as Nupercaine.® Using cocaine as a standard, and assigning to it

ANTIBACTERIAL SPECTRA OF ANTIBIOTICS RECOMMENDED FOR LOCAL TREATMENT(6)

Antibiotic	Hemolytic Staphylococci (Coagulase Positive)	Hemolytic Streptococci	Proteus	Pseudomonas	Misc. Gram-Negative Bacilli
Bacitracin	++	++	−−	−−	−−
Chloramphenicol	+++	+++	+++	++	++
Chlortetracycline	+++	+++	−−	+	+++
Neomycin	++++	++	+++	+++	+++
Oxytetracycline	+++	+++	±	+++	+++
Polymyxin B	−	−	−	++++	−

a toxicity index of "1" he found the following toxicity indices:

Benzocaine	1/10	Larocaine	1
Procaine	¼	Holocaine	2
Metycaine	¾	Butyn	2½
Diothane	¾	Pontocaine	3 to 5
Cocaine	1	Nupercaine	5

Adriani and Campbell, in a study regarding toxicity of local anesthetics, employed the 20% dissolved benzocaine ointment nearly 10,000 times as a lubricant for intratracheal catheters and for pharyngeal and nasal airways to obtund the pharyngeal and tracheal reflexes without any untoward effects. They report that because of the insolubility of benzocaine it is absorbed more slowly than other drugs and that untoward reactions due to either systemic toxic effects or sensitivity are virtually unkown from the use of this substance.[8]

5. *No Interference With Epithelization.* Epithelization, while using the benzocaine-neomycin ointment, takes place from the outer edges inward at a normal rate. It forms a satisfactory environment for proliferation from glands and follicles. Sometimes the depth of a burn cannot be ascertained initially but becomes evident in a few days, when dead skin begins to separate, making possible the evaluation of numbers of epithelial island proliferations from remaining viable sweat gland crypts and hair follicles. White and Madura observed that the topical anesthetic, by its antipruritic action, may be helpful in hastening epithelization by allowing the tissues to rest.

6. *Does Not Cause Maceration.* Proponents of the open wound method of burn therapy have pointed out that occlusive dressings promote infection by preventing adequate drainage. The benzocaine-neomycin ointment utilizes a water-soluble base, which permits free local drainage and at the same time is bacteriostatic. No case of maceration or delayed healing from the use of the ointment was observed. Likewise, it was noted that the ointment prevented clotting into or dried attachment onto the bandage so that it was removed easily, painlessly, and did not stir up bleeding or molest any early epithelization which had taken place.

7. *Keeps Eschar Soft.* Thus the healing process is never dry or prone to cracking, while allowing the usual motions of skin in everyday living routines. Rebandaging, always a traumatic procedure to patient and wound, loses its attendant risk of pain and infection. Multiple debridements are affected by the ointment in this method of treatment.

8. *Easy to Apply.* After initial dressing, the patient may apply the ointment in the simple manner of squeezing the tube. It was found that strict sterile precautions are not necessary after the initial dressing plus 24 hours.

9. *Adaptability.* The ointment is relatively economical; it may be used in any climatic condition; it may be stockpiled up to two years; and refrigeration is unnecessary. This makes it ideal for mass casualties in the event of industrial, military, or civilian disaster. For casualty cases which need first aid, prior to transportation to more definitive treatment, ease of handling would not be impeded and ointment without large bandages would not hide other wounds.

In the present study, all patients had first and second degree burns. Systemic needs were not demanding. Tetanus antitoxin or booster toxoid was administered in all cases, but no systemic antibiotics were given. The majority of our cases were dry thermal burns of hot glass or hot metal. Some were wet thermal or hot water. Flames, chemicals, and steam are serious in that they frequently induce wet or dry necrosis. Two cases were infected from treatment by other means at home and immediately cleared under the benzocaine-neomycin ointment. The affected areas were cleansed with a non-alkaline-hexachlorophene detergent and sterile saline or water. Alkali, as found in usual soaps, tends to cause dissolution of epidermal cells.[10] All blebs, blisters, and loose and necrotic tissues were debrided with sterile scissors and thumb forceps. Either one of two ointments under study, i.e. benzocaine-neomycin or sterile petrolatum jelly, was applied with sterile tongue depressors or sterile rubber gloves. It is important to apply the ointment well beyond the obviously burned area; burns may extend far beyond the area seemingly affected on first inspection. A pressure bandage was employed for six hours; the dressing edges were carefully taped firmly to the skin around the entire perimeter. The patient then reapplied ointment as needed for relief of pain. Similar redressing without pressure was performed to wipe

TABLE 1

RESULTS OF TREATMENT OF BURNS WITH BENZOCAINE-NEOMYCIN OINTMENT

Type of Burn	*Number Patients*	*Relief of Pain*	*No Infection*	*Infection*	*Result Scar*
Wet Thermal	6	Excellent	6	None	No apparent effect
Chloride of Lime	2	Excellent	2	None	"
Dry Thermal	83	Excellent	81	2	"
Sunburn	4	Excellent	4	None	"
Infected by previous treatment	2	Excellent	2	None	"
	97		95	2 (2%)	

away secretions in 24 hours. Thereafter the patient was seen daily for observation only. Instructions were given the patient to apply the ointment from the tube every 4 to 6 hours, after washing the hands, if pain required reapplication of ointment.

Table 1 summarizes the results of treatment with the benzocaine-neomycin ointment. Relief of pain was strictly a clinical evaluation of the patient. Infection was tested by sterile swab on gram stain slides and culture of 24 hours. This was done only when gross indications of infection were apparent. None were swabbed prior to treatment.

The procedures for application of sterile petrolatum and redressings were identical with those followed in applying the tested ointment. The number of cases at random and results from using sterile petrolatum as alternative dressing as a control are shown in Table 2. It was readily evident that the discomfort and infections were attributable to maceration and prevention of drainage. This bears out the findings of Wilson, Kimball, and Swenson.[9] In some cases the impounded moisture made the surrounding rim of the wound turn the soft white color of wet necrosis. In two cases the complaint of itching was issued. Only 12 cases were used as controls because satisfactory results are necessary in an industrial medical service in order to maintain employee confidence.

In the 97 cases treated with the benzocaine-neomycin ointment, all obtained prompt and satisfying relief. A few patients complained of slight stinging when the ointment was first applied but this sensation lasted only a few seconds, after which relief appeared excellent. Of the 97 cases, two developed mild Staphyloeoccus aurens infection after the third day. In all other cases, infection was apparently controlled. This is in contrast with four cases of infection out of 12 using sterile petrolatum.

SUMMARY

A clinical study of treatment of first and second degree burns with an ointment containing 20% dissolved benzocaine and 5 mg. neomycin sulfate per gram to control pain and infection, using 97 cases, showed prompt and excellent relief of pain in all instances; 95 cases were kept free from any resulting infection.

Using sterile petrolatum as a control on 12

TABLE 2

RESULTS OF TREATMENT OF STERILE PETROLATUM JELLY

Type of Burn	*Number Patients*	*Relief of Pain*	*No Infection*	*Infection*	*Result Scar*
Dry Thermal	10	6-Moderate	7	3	No apparent effect
		4-Poor		(Staphylococcus aureus)	"
Wet Thermal	2	Claimed no relief	1	1 (Pseudomonas)	"
	12		8	4 (33 1/3%)	







cases, relief from pain was only moderate in six cases and poor in six. Four patients, or 33-1/3%, developed resultant infection.

From our study, it would appear that this benzocaine-neomycin ointment provides an excellent means of controlling both pain and infection of burns. There was no interference with epithelization and normal healing occurred. It appears to be nontoxic and not a single case of sensitivity or untoward reaction was observed.

ILLUSTRATED CASE

S.L.S.: A 25 year old white male sustained second degree burns on his right hand while at work on the forming line in a glass bottle factory. The hand was caught in a hot empty mold blank which seared through his cotton glove. The first illustration shows charred fragments of the glove which clung to the blistered area. Pain was severe, but the individual was stoic and no symptoms or signs of shock appeared. The second photograph shows the hand 24 hours following debridement and treatment with Americaine w/Neomycin. Pain was relieved immediately. No subsequent infection occurred. Minimal scarring resulted as shown in third picture taken 30 days later which would indicate a long narrow area of possible third degree involvement.

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CASE REPORTS

Mongolism and Metaphyseal Aclasis

JANET D. ROWLEY, M.D.* AND MARTIN L. SCHWARTZ, M.D., CHICAGO

THE purpose of this report is to record the dual occurrence of two rare disorders, metaphyseal aclasis and mongolism in a female child. In our series of over 150 cases of mongolism at the Dr. Julian D. Levinson Research Foundation this is the first instance of the simultaneous occurrence of these two disorders. We have found no report of a similar case in a review of the literature.

Metaphyseal aclasis[1] has been variously named: Hereditary deforming chondrodysplasia[2], multiple hereditary osteochondromatosis[3], hereditary multiple exostosis[4], and diaphyseal aclasia[5]. The exostosis occur most frequently in the area of the metaphysis and the term, metaphyseal aclasis, would appear to describe this condition most accurately. One theory postulates that the bone deformities result from a disarrangement of the epiphyseal cartilaginous plates and a deficiency of the ring of metaphyseal periosteum[1]. The former causes bone to grow out at an angle from the normal contour of the bone; the latter causes a failure of the modeling process of the metaphysis, resulting in the metaphysis being the same width as the diameter of the epiphyseal line. The lesions are most frequent where bone growth is greatest.

The defect causing metaphyseal aclasis is transmitted as a mendelian recessive[5]. The hereditary nature of the disorder is well demonstrated by our family history. (Figure 1)

Case Report: Our patient is a white female born October, 1946. The pregnancy and delivery were uneventful. A heart murmur was noted when she was an infant. She sat alone at

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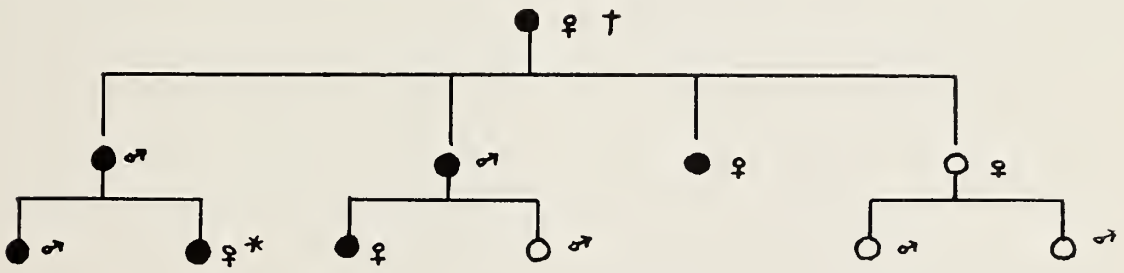


Figure 1.—The known incidence of metaphyseal aclasis in the patient's family.

†—paternal grandmother was one of eleven children and was the only one of her generation known to have the disorder

*—patient

•—presence of metaphyseal aclasis

o—normal bone formation

9 months, walked alone at 22 months, and was saying sentences at age 6. Thyroid 1/10 grain every other day was started at age one week. It was gradually increased to 2 grains a day at age 5. She remained on this dose except for two periods of 4 and 6 weeks. When thyroid medication was stopped the mother noted that the child was sluggish and gained weight easily.

Physical examination: The patient's first visit to the clinic was in March of 1955 when she was 8½ years old. Her weight was 24.1 kg., height 115 cm., head circumference 48.75 cm., and chest circumference 57.5 cm. Her head was both microcephalic and brachycephalic. She had a number of other mongoloid characteristics: Her eyes were widely spaced with somewhat slanting palpebral fissures; her ears were small and the lobule was absent; her tongue was furrowed and the palate high and narrow; she had broad hands, bilateral palmer lines, and a short curved little finger; and a wide space between her great and second toes. Other abnormal physical findings were a mild proptosis, whitish plaques at the periphery of both central incisors, serrated lower central incisors, and webbing of the second and third toes bilaterally. A soft systolic murmur was heard on one occasion. Exostoses were palpable on the medial third of both clavicles, proximal end of both humeri, distal third of both radii and ulnae, and the middle phalanx of the index finger bilaterally. A markedly widened appearance to the leg just below the knee was due to the exostoses in the upper third of the tibia and fibula bilaterally. She walked with her feet in marked pronation.

Her I. Q. as measured by the Stanford-Binet Intelligence Scale, Form L, is 60. This is above the mean I. Q. (48.6) for our first 50 mongoloid children.[6] She has a good understanding of speech. In speaking, the patient omits most of her consonant sounds but uses good vowel sounds. She does not have too good control of her tongue. Her hearing is normal.

Laboratory Data: Hemoglobin 78%, R. B. C. 5.95, W. B. C. 11,000, and color index .66. The urine was negative for albumin, sugar, acetone, and bile. X-ray survey of the skeleton revealed exostoses on the clavicles just lateral to the sternoclavicular joint, in the upper third of both humeri, and the proximal end of the radius and distal ends of the radius and ulna bilaterally



Figure 2.—X-ray of left upper extremity. Exostoses are present in proximal humerus, proximal and distal radius, distal ulna, second metacarpal, second proximal phalanx, and fourth and fifth middle phalanges. The shortening of the ulna with the resultant bowing of the radius is clearly demonstrated.

(*Figure 2*). On the right the fourth metacarpal, second middle phalanx, and third proximal, middle, and distal phalanges are affected. On the left the second metacarpal, second proximal phalanx, and fourth and fifth middle phalanges are affected. In addition exostoses are present in the pelvis, especially on the pubic arch, on both ends of the femur with marked widening of the distal metaphysis of the femur bilaterally (*Figure 3*) on both ends of the tibia, and on the distal metaphysis of the fibula bilaterally. There is a 1.5 CM. shortening of the left tibia as compared with the right. The left fibula is 3.3 cm. shorter than the right. This unequal shortening results in distortion of the lower articular surface of the tibia-fibula on the left. This same shortening is present in both ulnae with resultant bowing of the radii about equal bilaterally.

X-rays also revealed abnormalities occurring frequently in mongoloid children. The frontal and occipital bones of the skull are thin, which



Figure 3.—X-ray of the pelvis and both femurs. Exostoses are present on pubic arch, neck of the femur, and distal metaphysis of the femur bilaterally.

is in agreement with Benda.[7] The middle phalanx of the little finger is moderately hypoplastic and curved; this characteristic has been noted by other investigators[7,8,9].

COMMENTS

The patient has made progress both mentally and physically. She attends a school for retarded children in the morning and goes to school with normal children (second grade) in the afternoon. While she cannot compete with the normal children academically, her social behavior is normal and she is accepted by the other members of the group. She has no disability resulting from the exostoses. In a normal child the pelvic exostoses would have to be evaluated in relation to pregnancy.[10]

The etiology of mongolism is unknown. Its association with an inherited disorder in this particular patient is probably a coincidence. However, one cannot exclude heredity as an etiologic factor in producing mongolism. Further investigation of this problem is indicated.

SUMMARY

A case of metaphyseal aclasis associated with mongolism is presented. No similar case report has been found in a review of literature.

Metaphyseal aclasis is an inherited disorder. The etiology of mongolism has not been established.

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An Unusual Cause of Death

Samuel K. Lewis, M.D., Elmhurst

CESSATION of physical life is never without cause. If the passing has been sudden, without recent medical care, the case should be referred to the Medical Examiner; in Illinois known as the "archaic" county coroner.

Case No. 52-75 was a full term 7-½ lb. male infant of a young primipara. Gestation and birth were normal. On the fourth day of life, just previous to dismissal from the hospital nursery, a well qualified pediatrician examined the baby and found no physical abnormality. At home, when seven days old, a body temperature of 103 degrees was observed for twelve hours. This temperature subsided without medication. The baby nursed well at breast until the thirteenth day and had begun to gain weight. He was not seen by a physician from the fourth to the thirteenth day of life. On this last day, the infant suddenly became apathetic. A physician who had not previously seen the baby felt he was very anoxic. Police rushed the baby to the hospital where he was dead on arrival. Thus it became a medico-legal case.

The young father and mother were hysterical but co-operative. The coroner explained the value of an autopsy and the parents understood that they would be informed of all pertinent facts. Their only question was the usual one, "What could we have done wrong? As coroner-physician I proceeded with the necropsy and report the following findings:

The examination of the chest and abdomen was not revealing. They were carefully re-examined after the brain was sectioned. In the examination of the brain, an extremely extensive neoplastic lesion was found, replacing more than one-half of the right cerebrum. Because of its size and the age of the infant, this neoplasm was obviously present before birth. The tumor portion in the sagittal plane measured 8 x 9 cm. as compared with an AP measurement of the overall specimen of 14 cm. The tumor was solid and had a battleship gray color as compared to the normal color of the surrounding tissue.

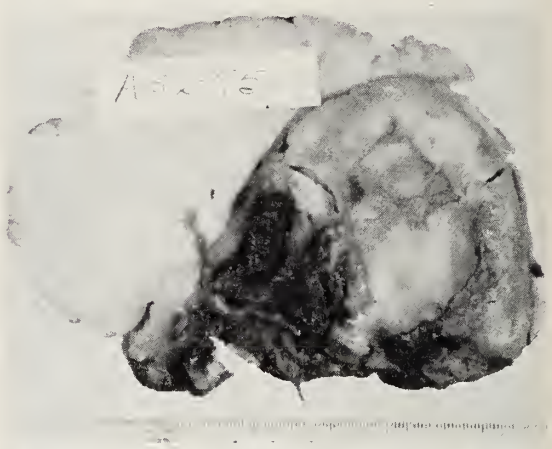


Figure 1. Sagittal section shows difference in size, color and compactness of tumor and brain tissue.

I am indebted to Harold D. Palmer, M.D. for the microscopic diagnoses which follow, and concurrence in the same by William H. McNamara, M.D.

The sections present an extremely cellular tissue which is obviously neoplastic. The type cell is quite uniform in appearance. It includes small spherical or oval nuclei which are rather vesicular in structure and contain no prominent

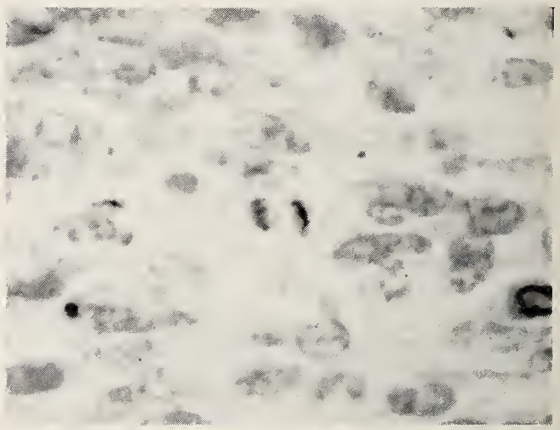


Figure 2. Photomicrograph shows mitoses, uniform shape, and size of type cells.

nuclei. The cells tend to bundle and arrange themselves in strands in some areas. This gives the cells a spindle or bi-polar appearance.

Mitotic figures are quite numerous throughout the lesion. Chlorazol black and phosphotungstic acid hematoxylin stains show an abundance of glial fibers about and continuous with the extremities of the cells. Where the tumor abuts onto normal tissue there is depression and extension by invasion.

Diagnosis: Spongioblastoma polare of the brain.

Discussion: Sudden unexplained neonatal deaths in this area each year average 10 per 100,000 population. Diagnosis of cause of death frequently is difficult. Accuracy and thoroughness must be improved if our Public Health statitics are to be of value. The diagnosis should always be fully explained to the next of kin by a physician. This is an invaluable public relations project and worthly of component society encouragement.

It was not until 1937 that Stern pointed out that pathological brain tissue that had previously been called tuberculomas when studied, were found to be tumors. Mitoses in brain tumors are an infrequent observation. Congenital tumors are rare; especially congenital brain tumors. One more is added to the few that have been reported. This is a sequel to a thorough investigation of a coroner's case in DuPage County, Illinois.

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Tuberculous spondylitis

In the preantibiotic era treatment of tuberculous spondylitis consisted of long periods of bed rest (one to three years or even longer), with fixation of the spine by various frames or plaster casts. With the use of streptomycin, para-aminosalicylic acid, and the nicotinic acid derivatives, however, the outlook in the treatment of tuberculosis has become brighter, and this also is true of Pott's disease. Gold and associates report encouraging results in the treatment of skeletal tuberculosis with the use of streptomycin and isoniazid. There is decreased toxicity, increased appetite, gain in weight, improved general well being, and maintenance of approximately normal body temperature. There seems to be more rapid control of the activity of the tuberculous lesion. Bosworth and Fielding, in reporting the use of the newest nicotinic acid derivative, iproniazid (Marsilid®), state that this is the drug of choice and that it is especially valuable in the treatment of patients not responding to the other drugs. They also claim that with the use of iproniazid, they may be able to spare arthrodesis of the joint. Supportive treatment with diet, fresh air, sunshine, and good nursing care still is indicated. In 1911 Hibbs did the first bony fusion operation, using a bony splint extending from two vertebrae above the involved area to two vertebrae below. Surgery, it is agreed, decreases the amount of deformity and diminishes the length of the hospital stay. Laminectomies to relieve pressure of an abscess causing paraplegia have had disastrous results in practically all patients, and this type of treatment is not advocated. Present day therapy with the newer antituberculous drugs needs further evaluation on a larger number of cases but results to date have been most encouraging with more rapid decrease in toxicity, control of tubercular activity, diminution of deformity, and the possibility of avoiding surgery in the future. *Gene-Ann Polk, M.D. et al. Tuberculous Spondylitis (Pott's Disease) of the Cervical Spine. New York J. Med. July* 1, 1957.

EDITORIALS

Stress and atherosclerosis

The relationship between stress, serum cholesterol, and atherosclerosis was the subject of much debate at the October meeting of the American Heart Association in Chicago.

Rosenman and Friedman, of San Francisco, presented evidence that stress raised the serum cholesterol and the blood clotting time. Bimonthly tests were made on a group of 42 volunteer male accountants during the first six months of 1957. In 83 per cent of the entire group, the highest readings in each individual (260 mg.) were obtained during their periods of maximal stress, while meeting three tax deadlines. Conversely, in 76 per cent the minimal serum cholesterol (197 mg.) occurred at times of least stress.

Hammarsten, Cathey, Redmond, and Wolf, of Oklahoma City, reported somewhat similar results in a series of 12 male subjects who had survived a well documented myocardial infarction. Each was asked to keep a daily record of what he ate. Their diets, relatively high in cholesterol and fat content, were maintained at the same level throughout the observation period. In addition, each person was studied carefully from the standpoint of his life adjustment and the events of his day by day experience. Significant variations in the serum cholesterol were noted from week to week. But on 20 occasions, the level climbed higher than would be expected on the basis of normal variations; in 19 of these instances, the increased cholesterol level corresponded with intervals of particular stress.

The relationship between stress and the complications of atherosclerosis, such as coronary thromboses, is in keeping with the usual clinical experience. The effect of stress on blood clotting is more significant because thromboses are a common sequela of atherosclerosis. The blood clotting time in the series of cases by Rosenman and Friedman was shortened from an average of 9.4 minutes, during the interval of minimal stress, to 5 minutes during maximal work stress. These new findings do not detract from the dietary etiology of atherosclerosis. There are many facets to this problem and our current attempts to lower blood cholesterol with a diet are reminiscent of the trial and error dietary treatment of diabetes prior to insulin.

The possibility that serum cholesterol is controlled by a hormone was suggested by Zarafonetis and associates in Philadelphia. They isolated a lipid mobilizer (LM) hormone that raises the level of cholesterol, fatty acids, and lipid phosphorus in blood. In animals, LM in plasma increases during stress conditions, including starvation, and by the administration of cortisone.

An abstract in the Proceedings of the Central Society for Clinical Research (1957) gives a report by Zarafonetis and his group stating that

the concentration of plasma LM increases, along with the plasma lipid, prior to surgery. This is additional evidence that stress plays an important role in hypercholesterolemic states.

Basic research of this nature is helping to piece together a gigantic puzzle. Every year it comes nearer to completion and many authorities are beginning to distinguish the trees in the forest.

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Dr. Coleman honored

Dr. Everett P. Coleman of Canton, Ill., a past president of the Illinois State Medical Society, was presented the Illinois Welfare Association's public service award at the organization's annual conference in Chicago, November 4.

Dr. Coleman was honored for his contribution to improved medical care for persons on relief.

He is one of the Illinois State Medical Society's most indefatigable workers. He is an active member of the Committee on Medical Service and Public Relations, Committee on Medical Licensure, Committee on Nursing, Rural Health and Student Loan Fund Committee, Committee on Scientific Exhibits, and Committee on Scientific Awards. For many years, he also was chairman of the Advisory Committee to the Illinois Public Aid Commission. He is also a delegate from Illinois to the American Medical Association's House of Delegates. He is president of the Graham Hospital staff in Canton.

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The new narcotics act

In the October issue of the Illinois Medical Journal, Mr. Walter L. Oblinger, Associate Counsel at Springfield, reviewed some of the recently enacted legislation affecting medical practice. One of these subjects was a discussion of the new Narcotic Act. Mr. Oblinger inadvertently failed to mention that the effective date of the Act is January 1, 1958. Accordingly it will not be necessary to make any changes in the method of dispensing, or prescribing narcotics until January 1, 1958.

Several readers wrote the editors asking for additional information and especially the date the new Act would take effect, and Mr. Oblinger has asked that this information appear in the December issue of the Journal.

Name advisory committee to medical assistants

The Council of the Illinois State Medical Society at its October meeting approved the appointment of Drs. Carl E. Clark of Sycamore (chairman), Newton DuPuy of Quincy, Caesar Portes of Chicago, and Arkell M. Vaughn of Chicago as members of an Advisory Committee to the Illinois Medical Assistants Association.

The Illinois association is a part of the American Association of Medical Assistants, which has the approval of the AMA. The annual meeting of the Illinois group will be held in Chicago on April 12-13, 1958.

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Second Illinois Congress on Maternal and Infant Care

The second annual Congress on Maternal and Infant Care will be held at the Pere Marquette Hotel in Peoria, February 4-6, 1958, under the sponsorship of the Illinois Committee on Maternal Welfare. The theme for this second congress is "Illinois Moves Forward in Maternal and Infant Care." Subjects to be discussed will revolve around the interprofessional approach to maternal and infant care, and all interested health professions are being invited to participate in the program.

Traditionally, members of the medical profession have met together in closely knit, specialized societies. This new organization does not want to supplant these groups, but proposes to offer itself to all these professional groups as a forum where they can come together for the exchange of ideas, and the formulation of new thinking. The purpose of the Congress is to help mothers and their babies to profit from the coordination of these ideas through a co-operative, or "team approach" to their problems.

To date, only a tentative program has been arranged for the second annual Congress, but more information will be available within a short time. In addition to the long list of Illinois physicians heading the several specialties, and general practice, there are hospital administrators, nurses, public health officials, nurse anesthetists, dietitians, and others who will participate in this Congress. Advance registration forms may be procured by writing to the Illinois Committee on Maternal Welfare, 116 South Michigan Avenue, Chicago 3, Illinois.

MEDICAL ECONOMICS



1. Union Medicine

2. New Drugs

John R. Wolff, M.D., Chicago

One of the facts of everyday living is the realization that the labor union is interested in the health and welfare of its members. Tremendous sums of money have been collected by the unions and are now being utilized for this purpose. The mine workers, garment workers, flat janitors and several other organizations have established techniques of meeting this health problem. This problem is sure to grow. It concerns large numbers of people, the funds are prosperous, and the union leaders are anxious to show results.

It would be well for medicine to sit back and say that all payment of fees should be between the patient and the physician. This ideal is not realistic in today's economy. No physician likes to contemplate the possibility of a third party controlling medical finances. The dangers are obvious, since he who controls the purse strings becomes the master.

An important point to keep in mind in all negotiations over such problems, is that our medical society can give only advice. Each physician must make his own decision concerning his attitude and desires.

The Medical Service and Public Relations Committee of the Illinois State Medical Society is well aware of the present problems. Many communities also are concerned. There is information in abundance for you. But again, doctor it is up to you as an individual to alert yourself to the economics of the day.

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In a recent article in the J.A.M.A., Dr. Harry Dowling, Professor and Head of the Department of Medicine at the University of Illinois College of Medicine, called attention to the need for the careful evaluation of a new drug before the clinician puts it to use. He pointed out that the new drug is often placed on the market with a minimum of clinical research, that it is presented as a "wonder drug" and that physicians are urged to use it before its true place in medicine has been determined. A recent editorial in the Illinois Medical Journal stated that if you want to know about new drugs, don't call your physician, call your stockbroker.

Such warnings are wise and to the point. Ethical pharmaceuticals have become big business. The drug companies spend fortunes in research. In so doing they are contributing greatly to human welfare. They deserve the profit obtained from a new discovery. This profit can be plowed back for more research leading to greater discoveries. With competition as great as it is, the drug concern must attempt to sell its product to the profession.

It is up to the physician to evaluate carefully

the efficacy of the new drug. Certainly, this is being done. The final yardstick to the drug concern is how the product sells. This is also a good indication of the medical value of the drug, since if it is truly a miracle one, it will be utilized by all physicians. We need not criticize the drug company. We should encourage the physician to continue to use careful judgment and to remember to be neither the first nor the last to use the new drug.

However, today it is not uncommon for the physician to obtain his first notice of a new drug from the daily newspaper or one of the monthly magazines. This is due to the excellent "nose for news" of our reporters. A danger is that the physician may misconstrue this procedure. It may be seen as a tendency of the drug concern and its public relations department to create public interest and a demand for the drug before the doctor has sufficient scientific knowledge of its value. Many drugs have reached the market with such a preliminary background, only to be found wanting. As time marches on it might be better for the enterprising business concern to increase its values of ethics and pay less attention to the profit of the moment. In the long run the reward will be greater.

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Atherosclerosis

The finding of statistical association of plasma cholesterol levels with clinical coronary artery syndromes is consistent with the long entertained proposition of a direct causal relation between cholesterol levels and the development of human atherosclerosis. Such a relation remains an assumption and is not established. The pathogenic mechanism and proximate cause or causes of lipid accumulation in the arterial wall are unknown. If plasma is the direct source of depositing lipids in atherosclerosis, it remains to be demonstrated whether pathogenicity resides with one or more new lipoprotein fractions, or some unidentified fraction, or equally with all plasma cholesterol—whatever its physical, lipoprotein, or molecular associations. Some authorities hold that atheromatous lipid arises from local synthesis in the arterial wall rather than directly from infiltration of plasma lipids, and others deny a primary role of either lipid transport or lipid synthesis, blaming such factors as repeated mural thromboses and intimal hemorrhages as the origin of both the hyperplastic reaction and lipid accumulation. The association between cholesterol levels and clinical coronary artery disease may not be an etiologic one. Also, lowering of plasma cholesterol by such means as ingestion of unsaturated oils may not be accompanied by the same effect on atherosclerosis as that resulting from a diet low in fats. On theoretical grounds based on present knowledge, it is not possible to predict what influence unsaturated oils will have on atherogenesis or resulting clinical syndromes. Clearly, however, the provocative nature of the present situation urges large scale, carefully planned, and carefully executed investigations. Such studies are mandatory for the proper evaluation of possible clinical benefit from unsaturated oils in atherosclerotic syndromes. Medical science often has had to learn that associations between observed phenomena are not always what they seem. In a problem as momentous and population encompassing as preventive measures directed against atherosclerotic disease, it is imperative that any major dietetic alteration or supplement be based on soundly established data. *Editorial. Agents for Lowering Plasma Cholesterol. New England J. Med. Oct.* 10, 1957.

CORRESPONDENCE

Course in radiation physics

The annual course in radiation physics for residents in radiology at the hospitals associated with Northwestern University Medical School will again be open to all interested physicians.

It will be given on Monday evenings 6:45 to 9:00 p. m., January 6 through April 14, 1958, at veterans Administration Research Hospital, 333 E. Huron Street, Chicago 11, Illinois. Tuition fees: Residents—$15.00, Practicing and other Physicians—$35.00.

To make application write to: Director Graduate Division, Northwestern University Medical School, 303 E. Chicago Avenue, Chicago 11, Illinois.

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Clinics for crippled children listed for January

Twenty three clinics for Illinois' physically handicapped children have been scheduled for January by the University of Illinois, Division of Services for Crippled Children. The Division will count 19 general clinics providing diagnostic, orthopedic, pediatric, speech, and hearing examination along with medical, social, and nursing service. There will be 2 special clinics for children with cardiac conditions, 1 for children with rheumatic fever, and 1 for cerebral palsied children.

Clinics are held by the Division in co-operation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

January 3 — Chicago Heights (Cardiac), St. James Hospital
January 8 — Hinsdale, Hinsdale Sanitarium
January 9 — Sterling, Community General
January 9 — Mt. Vernon, Masonic Temple
January 9 — Clinton, Christian Church
January 9 — Springfield, St. John's Hospital
January 14 — E. St. Louis, St. Mary's Hospital
January 14 — Peoria, Children's Hospital (St. Francis)
January 14 — Quincy, St. Mary's Hospital
January 15 — Joliet, Will County T.B. Sanitarium
January 16 — Elmhurst (Cardiac), Memorial Hospital of DuPage County
January 16 — Flora, Clay County Hospital
January 16 — Rockford, Rockford Memorial Hospital
January 21 — Effingham (Rheumatic Fever), St. Anthony Hospital
January 21 — Danville, Lake View Hospital
January 21 — Alton, Alton Memorial Hospital
January 22 — Aurora, Copley Memorial Hospital

January 22 — Evergreen Park, Little Company of Mary Hospital
January 22 — Springfield (Cerebral Palsy), Memorial Hospital
January 23 — Cairo, Public Health Building
January 23 — Decatur, Decatur-Macon County Hospital
January 28 — Peoria, Children's Hospital (St. Francis)
January 29 — Salem, Masonic Temple

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A rehabilitation program

Physical rehabilitation of injured workers is "part and parcel" of medical care under workmen's compensation, according to "A Rehabilitation Program," a booklet just published by the Association of Casualty and Surety Companies.

The booklet discusses medical rehabilitation, workmen's compensation, Federal-state vocational rehabilitation and then, in step-by-step fashion, presents a major plan for the establishment, by any carrier of workmen's compensation insurance, of a well organized rehabilitation program as a part of regular medical services and a method for extending that plan to provide close liaison and referral arrangements with vocational rehabilitation services when needed.

The program, drafted by the Advisory Committee of the Association's Claims Bureau, is based on the premise that "the carrier-sponsored physical rehabilitation program on the compensation case will prove the most effective in returning the injured workman to employment and self-sufficiency in the shortest possible time." It has been recommended by the Association for the consideration of its 141 capital stock casualty and surety member companies.

In announcing publication of the booklet, J. Dewey Dorsett, general manager of the Association, called attention to the fact that physical rehabilitation is a matter of common concern to employers and employees, to state agencies, the medical profession and to the insurance industry.

"This recommended program," he said, "should be particularly valuable as a means of clarifying some of the issues and problems of physical rehabilitation and as a step toward the ultimate development of the most effective physical rehabilitation program."

Copies of the booklet, in reasonable quantities, are available to interested groups and individuals at no cost. Requests should be addressed to the Public Relations Department, Association of Casualty and Surety Companies, 60 John Street, New York 38, New York.

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International Academy of Proctology award contest

The International Academy of Proctology announces its Annual Cash Prize and Certificate of Merit Award Contest for 1957-1958. The best unpublished contribution on proctology or allied subjects will be awarded $100.00 and a Certificate of Merit. The winning contribution will be selected by a board of impartial judges, and all decisions are final.

The formal award of the first prize, and presentation of other certificates, will be made at the annual convention dinner dance of the International Academy of Proctology, April 11, 1958, at the Hotel Del Prado, Mexico City, Mexico.

The International Academy of Proctology reserves the exclusive right to publish all contributions in its official publication, "The American Journal of Proctology." All entries are limited to 5,000 words, must be typewritten in English, and submitted in five copies. All entries must be received no later than the first day of February, 1958. Entries should be addressed to: ALFRED J. CANTOR, M.D., Secretary, International Academy of Proctology, 147-41 Sanford Avenue, Flushing, New York.

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Graduate fellowships in industrial medicine

The University of Cincinnati's Institute of Industrial Health is offering graduate fellowships in industrial medicine. The Institute, which is in the Graduate School of Arts and Sciences, provides professional training for graduates of approved medical schools who have completed at least one year of internship.

The three-year course of instruction, leading to the degree of Doctor of Science in Industrial Medicine, satisfies the training requirements for certification in occupational medicine by the American Board of Preventive Medicine. Two years are devoted to intensive academic and clinical study in the field of industrial medicine. A final year is spent in residency in an industrial

medical department or in some comparable organization.

Stipends for the first two years vary from $3,000 to $4,000 depending on marital status. In the final or residency year, a fellow is compensated by the organization in which he is completing his training.

A one-year course is also offered to qualified applicants with a possibility of a Master of Science degree.

Requests for additional information should be addressed to Secretary, Institute of Industrial Health, College of Medicine, Eden and Bethesda Avenues, Cincinnati 19, Ohio.

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The Joseph A. Capps prize

The Institute of Medicine of Chicago is offering an annual prize of $300 for the most meritorious investigation in medicine or in the specialties of medicine. The investigation may be also in the fundamental sciences, provided the work has a definite bearing on some medical problem.

Eligibility—Competition for 1957 is open to graduates of Chicago medical schools who completed their internship or one year of laboratory work within a period of five years prior to January 1, 1957, excluding their terms of service in the Armed Forces.

Time Limit—Manuscripts must be submitted to the Secretary of the Institute of Medicine of Chicago, 86 East Randolph Street, Chicago 1, not later than December 31, 1957.

The manuscript of the prize paper, as submitted, is to become the property of the Institute of Medicine of Chicago.

The prize winner may be invited by the Board of Governors of the Institute to present his paper at a meeting of the Institute.

If no paper submitted is deemed worthy of the prize, the award may be withheld at the discretion of the Board of Governors.

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Treatment of military personnel of the Army

Military personnel of the Army who are on authorized absence, should have in their possession Department of Army Form No. 31, "Request and Authority for Absence." The reverse side of this form contains instructions pertaining to medical treatment or hospitalization that may be required while a military person is absent from his home station. Failure to follow these instructions sometimes results in delay in processing bills for care provided by civilian physicians and hospitals. Physicians and hospitals who treat military personnel are urged to assist them in notifying the proper military authorities. The processing and payment of bills for the care of military personnel should not be confused with the Medicare program for dependents.

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THE P. R. PAGE



Civil defense is medical PR

The AMA-sponsored Eighth County Medical Societies Civil Defense Conferenee in Chicago, November 9-10, revealed a disturbing situation.

There is continued public lethargy toward preparations for big seale disasters. This was ascribed to three reasons:

(1) Lack of government leadership at national, state and local levels.

(2) A feeling of hopelessness before the weapons now available.

(3) Laek of understanding of the need.

Out of the two-day diseussions came this eonsensus:

(1) The public will hold the medical profession responsible for medieal care when disaster strikes.

(2) The medical profession is best equipped to provide the leadership which is laeking.

Both of these points fall within the scope of public relations. No matter whose fault the lack of preparations may be, the failure to provide adequate medical care for casualties when the need arises will be laid at the door of the medical profession. No amount of explanation will avail.

Survival of the injured and preservation of the health of the uninjured are the ehief medieal objectives of eivil defense. Planning must have as its nucleus preparations for medical eare. This can be done only under the direetion of physicians.

The intent of Congress in the passage of the Civil Defense Act was that eivil defense shall be primarily the responsibility of the states and their political subdivisions. The Federal Civil Defense Administration was created as a co-ordinating and advisory body. An amendment, passed in the House and pending in the Senate, would make eivil defense a joint responsibility of the federal government and states and their subdivisions.

This presents a threat. The medical profession carries a tremendous responsibility and unless it is organized and trained to meet these responsibilities on a voluntary basis, regimentation will neeessarily develop.

Much planning has been done in disaster preparedness, but no adequate national medieal plan has been activated. What has been proposed is largely in a paper stage. The need is for a projection of these plans into an active organization and effective training programs.

The AMA through its Council on National Defense has co-operated wholeheartedly toward producing a solution. The Civil Defense Conference, which was well-attended, by representatives from many states and large cities was a meeting point for the exehange of ideas and the bringing of total thinking on the problem up to date.

It was the feeling that if the movement is to proceed to a timely solution, sparking must come from the grassroots. A successful plan cannot be developed from the top down. The place to start is in a community. This must be narrowed even more by beginning at a eommunity hospital since the injured will gravitate toward sueh a point.

The logie is that here is where the medieal

staff, which must assume the leadership, meets every group whose help is required in setting up a civil defense program. Physicians are in contact with the administrator and trustees who must be sold on the idea of extending their inventories of supplies needed in the event of an emergency.

A community hospital also provides an excellent opportunity to reach women and other groups whose community interest is demonstrated by their hospital activities.

In any hospital program, room must be made for every segment of the community. There must be an educational campaign. The public must be informed that the medical profession is doing its part, but it cannot work alone.

Where there is lack of interest because of a feeling that small communities are not in danger of attack the people must be made to realize that target areas have expanded from a radius of a few miles to one of a hundred miles or more, and that if a large city is hit, the movement would be to rural sections. A town of 1,000 may be called upon to support 10,000 or more overnight.

The Joint Commission on the Accreditation of Hospitals makes the existence of a local disaster plan as a requirement for accreditation. In order to obtain 100 per cent participation of physicians the suggestion was made at the civil defense conference that it may be necessary to establish mandatory attendance at exercises as a requisite for a staff position.

Dry runs may become monotonous, but they may make the difference between success and failure if and when an emergency should arise. Measures taken under the pressures of a national disaster cannot be fully effective or economical unless there has been good pre-disaster planning.

This is a public relations selling job. Physicians, to whom the public looks for guidance in all matters medical, are in a good position to put the point across.

Nominations for service awards

County medical societies are reminded that they should submit their nominations for recipients of the annual awards of the Illinois State Medical Society to laity for outstanding service to health progress in Illinois.

Each year, two awards are made. One is given to a lay group which has contributed to the health welfare of the state. The other is presented to an individual layman whose contribution is worthy of recognition. Certificates are given to the selectees at the annual dinner of the Society.

The recipients of the award are chosen by the Committee on Medical Service and Public Relations from names submitted by the county societies. Suggestions should be sent as soon as possible to the Committee on Medical Service and Public Relations, 185 North Wabash Avenue, Chicago 1.

Getting along with reporters

John L. Bach, AMA director of press relations, gives sage advice on how to get along with reporters.

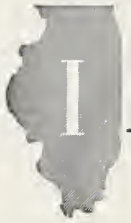
Usually the difficulty which arises between physicians and the press is the result of a lack of understanding. Mr. Bach suggests that physicians get to know newspaper writers well, especially those in their own communities.

"Work with them, and when the time comes that you need them you don't have to feel embarrassed in asking for what you want," he says. "Don't ignore them—and never fight with them."

Mr. Bach speaks from long experience. His close friendship with newspapermen all over the country, and the high regard they hold for him, attest to the wisdom of his advice.

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AT THE EDITOR'S DESK



RECENTLY, the Federal court ordered the Hoxsey Cancer Clinic, Inc., of Pennsylvania, to stop dispensing the Hoxsey treatment of internal cancer to out of state patients. Of interest is the following statement of George P. Larrick, Commissioner of Food and Drugs:

"FDA intends to seek rigorous enforcement of both the Pennsylvania injunction and the 1953 injunction issued by the Federal court of Dallas, but this will not end the menace of this treatment. The Federal government does not have the power to stop a clinic in any state from treating cancer patients within that state with the nostrums which comprise the Hoxsey treatment. Millions of copies of false promotional literature are still in circulation, much of it reporting cures of persons who are now dead. Cancer patients and their families who may be planning to try the Hoxsey treatment wherever it is available, are again urged to write to the Food and Drug Administration, Washington, 25, D. C., for the full text of its public warning."

The pharmaceutical and medicinal chemical industry expects to spend 127 million dollars in 1957 for medical and drug research. Ten per cent of this, according to Health News Institute, is in the form of contracts, grants, and fellowships to research institutes, foundations, hospitals, commercial laboratories and consultants, and other companies. The ethical drug industry spends more than twice as much each year on medical research as do philanthropic institutions, colleges, and universities combined; the federal government spends twice as much as the pharmaceutical houses.

A group of specialists in various health fields met at the Children's Bureau in Washington and agreed that an appeal to physicians was in order to restrain the use of X-rays in the care of infants and pregnant women.

Cavitron is the new ultrasonic dental unit that aims to eliminate the pain of drilling. In this device, the conventional dental drill with a rotating bur or diamond wheel is replaced by a rapidly oscillating working tip to which is applied a fine spray containing abrasive particles of aluminum oxide suspended in the air-water mixture. "The working tip moves up and down 29,000 times a second, covering a total longitudinal distance of only .0014 inches — a movement that is imperceptible to the naked eye. It gently urges the abrasive particles against the hard brittle areas to be cut."

The contraceptive action of the new synthetic steriods has created considerable speculation among physicians, church groups, and those interested in planned parenthood. At the last annual meeting of the Planned Parenthood Federation of America, the Puerto Rican director of

the organization described a study begun in 1956: 218 Puerto Rican women were given oral contraceptives and were instructed to take the tablets daily for 20 days, starting on the fifth day of the menstrual cycle. No pregnancies occurred while the medication was taken according to instructions, but some women reported unfavorable reactions to the pills.

Enovid is Searle's new synthetic female sex hormone. According to one of their news releases, the product is effective in controlling excessive, scanty, and painful menstruation as well as premenstrual tension. They expect it to correct certain types of infertility as well.

The poor old aspirin tablet continues to take a beating from a number of "better than" or "faster than" substitutes. The old reliable usually comes through, however, because it is cheap and effective. The latest substitute, Liquiprin, is a salicylamide suspension by Johnson & Johnson. It is touted as a new pediatric analgesic-antipyretic, safer than aspirin, and is administered via a calibrated dropper.

Tylenol Drops is McNeil's new dosage form of their antipyretic-analgesic pediatric drug. It contains "Tylenol" acetaminophen in a fruit flavored vehicle.

Fleet is now dispensing theophylline monoethanolamine (Clysmathane) in a disposable, plastic, rectal squeeze bottle for bronchial asthma and acute left ventricular failure. In time, this company may have a fleet of drugs for rectal administration.

The A. E. Staley Manufacturing Co. is the world's largest independent corn and soybean refining concern. It has introduced a safflower oil, available for shipment from Decatur in quantities ranging from gallon containers to tank car lots. Safflower oil is rich in unsaturated fatty acids, averaging 70 per cent linoleic acid. The latter is being recommended currently in combating hypercholesterolemia.

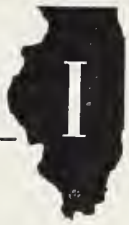
Most of the recent publicity on heart disease is on Merck's new nonmercurial diuretic, chlorothiazide (Diuril). This compound promotes the excretion of sodium and chloride in nearly equal amounts, thereby maintaining the electrolyte balance of the body. It is effective in controlling edema associated with cardiac insufficiency, cirrhosis of the liver and other causes. But the drug is proving to be of more value in treating hypertension, especially when used in conjunction with other antihypertensive drugs.

The Purdue Frederick Co. has combined reserpine with vitamin B_1 and B_{12} (Somatovite) for calming high-strung, nervous, irritable children. Then tranquilizing effects of this mixture produced a striking gain in weight and improvement in appetite in a group of 51 youngsters.

Chlorpactin XCB is reported to be helpful in destroying cancer cells that dislodge into the surgical field. It is manufactured by the Guardian Chemical Corp. for use in cancer surgery; it is of no value in the treatment of cancer.

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NEWS of the STATE



ADAMS

Dr. Charles L. Maxwell, of Chicago, deputy director of health of the Illinois Civil Defense Agency, was the speaker at the regular monthly meeting of the Adams County Medical Society, held at the Lincoln Douglas Hotel, Monday evening, Nov. 11. A dinner in honor of Dr. Maxwell preceded his address and the showing of the sound film "H Bomb Over Illinois." Dr. Maxwell stated that since Chicago is the second largest city in this country, it would be a key target for a bomb attack. An H bomb dropped on Chicago would produce tremendous casualties extending for a distance of about 50 miles in all directions from where the blast occurred. In addition, they would be great danger from radiation fall-out up to 220 miles away, depending on the direction of the wind.

An inspection of the 200 bed emergency hospital in storage at the Illinois S & S Home in Quincy was made by Dr. Maxwell, accompanied by Dr. E. L. Sederlin; Dr. Harold Swanberg; Mr. Wayne Messick, Adams County health educator; and Mr. P. K. Wagner, Adams County civil defense director. Dr. Maxwell told of the function of this hospital and its availability also in case of a great disaster of any kind.

Miss Geraldine Dillon, executive secretary of the Adams County Chapter of the American Cancer Society, showed the society's new sound film on the early diagnosis of carcinoma of the uterus. This is exceptionally well done and was warmly endorsed by the society for showing to all clubs of women.

The next meeting of the society will be on December 9. This will be the annual business meeting, with election of officers for 1958.

Dr. Miller Resigns.—Dr. Clare Miller has resigned as medical director of Hillcrest Sanatorium, Quincy, a position she has held since 1930. She joined the sanatorium staff after serving six years on the staff of Cook County Tuberculosis Sanatorium. Dr. W. H. McCain, internist on the staff of St. John's Crippled Children's School and Hospital, Springfield, has been appointed successor to Dr. Miller.

COOK

Hospital News.—On October 26 ground breaking ceremonies were held for a $4,000,000 addition to Holy Cross Hospital. When completed, the new 222 bed, five story unit will enable the hospital to care for 8,500 additional patients a year.

Plaques Honor Physicians' Veteran Service.—Twenty physicians who have served as staff members of Swedish Covenant Hospital for twenty-five or more years' service received certificates of honor at a dinner, October 26. The presentation took place at a benefit dinner sponsored by the hospital's service guild, the proceeds of which will be used to build a new postoperative recovery room in the hospital.

Physicians honored include Hjalmar L. Wallin, Leyden Township; William B. Stromberg Sr., Park Ridge; Robert G. Peschman, Evanston; Edward Hans; Karl L. Vehe; Gordon L. Rosene; Frank E. Nagel; Robert L. Borchert; Anders J. Weigen; Martin R. Broman, Evanston; Ralph A. Davis; William A. Jensen; Eva J. Line, Skokie (now deceased); C. Theodore Roberg, Sr.; Horace F. Smith, Park Ridge; John J. Vallancey, Greenville, Texas; Wesley Van Duine; John E. Waggoner, Downers Grove; Samuel J. Weiss, and Ralph G. Willy, Glenview. The record for longest service is held by Dr. Borchert who joined the hospital staff in 1914; the oldest staff member, no longer active, is Dr. Roberg, 81.

New Appointments.—Drs. William C. Offenkrantz and Robert S. Daniels have been appointed assistant professor and instructor, respectively, in the department of psychiatry at the University of Chicago School of Medicine. Dr. Offenkrantz comes to the university from the University of Southern California School of Medicine, Los Angeles, where he was assistant clinical professor of psychiatry. Dr. Daniels, who received the Stella Feis Hoffheimer Award from the University of Cincinnati College of Medicine for the highest grades in his medical class, recently completed a three year residency at his alma mater.

Dr. Loosli Goes to California as Dean.—Dr. Clayton G. Loosli, professor of medicine and chief of the section of preventive medicine at the University of Chicago School of Medicine, has been appointed dean of the University of Southern California School of Medicine, effective in July 1958. Dr. Loosli graduated at the University of Chicago School of Medicine. During World War II he was a consultant to the Secretary of War and a member of the Surgeon General's commission on influenza, pneumonia and air borne infections. He has written more than eighty articles on his research in acute respiratory diseases.

Personal.—A testimonial dinner was held in honor of Dr. Alfred A. Strauss, staff member of the Louis Weiss Memorial Hospital, October 23. Sponsor of the affair was the Physicians Committee of the State of Israel Bonds. Dr. Strauss was presented with a plaque which carried the following inscription: "In warm appreciation to Dr. Alfred A. Strauss in recognition of his outstanding achievements in the field of medicine and his support of civic and humanitarian causes. His profound interest in the preservation and strengthening of Israel has served to inspire the enthusiastic participation of the medical profession in the State of Israel Bond Campaign."—Dr. John L. Cutler, until recently staff physician at Elgin State Hospital, has been appointed acting superintendent of the New Tinley Park State Hospital. The unit has not yet been officially opened.—Dr. Emanuel E. Mandel, Glencoe, was recently appointed associate professor in medicine at the Chicago Medical School.—Dr. Oglesby Paul, clinical associate professor of medicine (Rush), University of Illinois College of Medicine, was recently elected a vice president of the American Heart Association.

Marie Hinrichs Honored.—Dr. Marie A. Hinrichs, director of the Bureau of Health Services for the Chicago Public Schools, recently received a distinguished service citation from Lake Forest College, her alma mater. Dr. Hinrichs, among other activities, serves as editor of the American Journal of School Health, as member of the executive committee of the American School Health Association, and is author of more than forty articles in the fields of general physiology and student health.

Professional Symposium for Medical Assistants.—The Chicago Medical Assistants Association held a professional symposium at the St. Clair Hotel, November 9, under the presidency of Miss Jessie Breinig. Participants included Wilbert E. Scheer, personnel director, Blue Cross-Blue Shield, "Better Employees Make Us Look Good;" Dr. Warren W. Furey, associate professor of radiology, Stritch School of Medicine of Loyola University, and Mr. George E. Hall, staff associate, Law Department, American Medical Association, "Medicine and the Law in the Physician's Office;" Dr. Albert H. Andrews, Jr., associate clinical professor of bronchoesophagology, University of Illinois College of Medicine, "What Makes a Para-Medical Society Click;" Miss Dorothy Bond, cartoonist, "How to Handle a Medical Man;" Mrs. Bettye Davis, past president, Chicago Credit Women's Club, "Credit and Collections," and Miss Zita Wist, past president, Lake Shore Chapter, National Secretaries Asso-

ciation, secretary to Dr. Morris Fishbein, "Much to Do About Manuscripts."

Cancer Series at Northwestern.—On November 12 Dr. Austin M. Brues, director of the division of biological and medical research, Argonne National Laboratory, gave the first in an annual series of lectures on cancer sponsored by Northwestern University Medical School. His subject was "Problems of Growth in Relation to Cancer." Dr. Averill A. Liebow, chairman of the department of pathology, Yale University School of Medicine, New Haven, spoke December 10. Other lectures are planned on surgery, January 14; radiology, February 11; obstetrics and gynecology, March 11, and medicine, April 8. Dr. William Wartman, professor and chairman of the department of pathology at Northwestern, is chairman of the series, and Dr. Thomas Harwood, instructor in pathology, is assistant co-ordinator.

New Headache Clinic.—Chicago Medical School has opened a clinic to study headache and its relationship to disturbed mental mechanisms. The clinic, made possible by a grant from Sandoz Pharmaceutical Company, has been set up as part of the school's neurological clinic at Mount Sinai Hospital. It is under the direction of Dr. Louis S. Schlan, clinical associate in neurology, and will be open Monday mornings from 9:30 a.m. to noon. Patients will be referred to the clinic from other parts of the hospital. They will go first to the neuropsychiatric department of the school where they will be given certain tests. Then they will be enrolled in the headache clinic for study and treatment.

Veda Latham Given Merit Award.—Dr. Veda Annette Latham, aged 91, was presented with a merit award by the Chicago Technical Societies Council at a dinner, November 7. The physician, who graduated at the Northwestern University Woman's Medical School in 1895, has held many honors, both in the fields of medicine and dentistry. A past president of the State Microscopic Society of Illinois, Dr. Latham is the first life member of the Illinois State Academy of Science. Dr. Latham was always greatly interested in pathology, and early in her career served as director of the pathological laboratory of the Woman's Medical College of Chicago. She held memberships in local, national and international organizations in medicine and dentistry, and throughout her career has been active in civic and community affairs. She is a member of the Fifty Year Club of the Illinois State Medical Society.

Society News.—At a recent meeting of the Hawaii Eye, Ear, Nose and Throat Society in Honolulu, Dr. Richard A. Perritt spoke on "Recent Advances in Corneal Transplantation Surgery" and "Present Status of Acrylic Lens Implants—Posterior and Anterior."—The Chicago Neurological Society was addressed recently by Drs. Harold Manfredi on "A Cerebral Vascular Anomaly;" Alex J. Arieff, Eli Tigay and Stanley Pyzik, on "Abdominal Reflexes in Patients with Injuries to the Spinal Cord," and William J. Fry, "Ultrasound—A Tool for Neurology."—The Society of Medical History of Chicago was recently addressed by Drs. Carroll L. Birch, professor of medicine, and Lester S. King, clinical professor of pathology, on "Subsequent History of One of Lecuwenhoek's Animalcules" and "Medical Ethics in the Eighteenth Century," respectively; both are on the faculty of the University of Illinois College of Medicine. Ilza Veith, Ph.D., associate professor of the history of medicine, University of Chicago School of Medicine, addressed the society recently, on "Concepts of Psychic Functions—East and West" and Dr. Noah D. Fabricant, clinical assistant professor of otolaryngology, University of Illinois College of Medicine, spoke on "Franklin D. Roosevelt, The Common Cold and American History."—Dr. Julius B. Richmond, professor and chairman of the department of pediatrics, State University of New York College of Medicine, Syracuse, N. Y., gave the second lecture in the eighth annual North Shore Hospital Lecture Series on "Emotional Problems of Childhood" November 6; his subject was "Management of Eating, Sleep and Rhythmic Habits."

Special Lectures.—Dr. William J. Baker, professor of urology, Northwestern University Medical School, gave the twenty-ninth annual William T. Belfield Memorial Lecture of the Chicago Urological Society, October 16, on "The History, Progress and Present Status of Cystoscopy as the Cook County Hospital."—Prof. H. L. Kottmeier, director of the Radium Hemmet, Stockholm, Sweden, delivered the eighth annual Joseph L. Baer Lecture of the Chicago Gyneco-

logical Society, October 18, on "Carcinoma of the Corpus Uteri."—Presentation of the thirteenth Edwin R. Kretschmer Memorial Lecture of the Institute of Medicine of Chicago featured the October 28 joint meeting of the institute and the Chicago Society of Internal Medicine. Dr. Joseph H. Burchenal, chief, division of clinical chemotherapy, Sloan-Kettering Institute, and professor of medicine, Cornell University Medical College, New York, gave the address on "The Search for More Effective Chemotherapy Against Leukemia."—"Leonardo Da Vinci: The Anatomist" was the subject of a special lecture on the history of surgery, November 7, sponsored by the International College of Surgeons; Dr. Elmer Belt, historian specializing in the history of the life of da Vinci, and formerly professor of surgery, College of Medical Evangelists, Los Angeles, gave the address.

KNOX

Society News.—A joint meeting of the Knox County Medical Society and its Woman's Auxiliary was held, October 17, in the Galesburg Club, with Dr. Milo Reed, president of the medical society, presiding. Mr. Walter L. Oblinger, Springfield, Associate Counsel for the Illinois State Medical Society, addressed the meeting on medicolegal problems.

LAKE

Boyd Memorial Lectures.—Dr. Irvine H. Page, director, Cleveland Clinic Research Foundation, delivered the Douglas Boyd Memorial Lecture, October 25, at the Highland Park Hospital. His subject was "Atherosclerosis and Diet." The lecture was established by the Highland Park Hospital Foundation in memory of the late Dr. Boyd, a former president of the Lake County Medical Society.

Society Guests of Accounts Service.—The Lake County Medical Society was entertained by the National Accounts Service, Inc., at a meeting in the Elks Club, Waukegan, October 8. After a social hour and dinner, the speakers were Mr. Gil Hamblet, sales director; Mr. Gordon Fletcher, president, and Mr. Regis Balkey, director of public relations, all of National Accounts Service, Inc. The services offered by the organization were discussed as well as some of the problems and situations which lead to a need for the services.

PEORIA

Pakistan Physician Gives Public Lecture.—Dr. Ronald Holland, Shikarpur, Pakistan, addressed a public meeting in the Methodist Hospital Auditorium, November 7, in Peoria, on eye problems encountered in oriental countries. Dr. Holland's father was Sir Henry Holland who started an eye clinic which is now the largest in Pakistan.

Society News.—At a meeting of the Peoria Medical Society at the Peoria Municipal Tuberculosis Sanitarium, November 19, Dr. Raymond C. McKay, medical director of the Cleveland City Hospital, spoke on "Compensation Problems in Occupational Pulmonary Disease."

ST. CLAIR

Society News.—At a meeting of the St. Clair County Medical Society in Augustine's Restaurant, Belleville, November 7, Dr. Joseph E. Graham, East St. Louis, spoke on "Endometriosis."

Personal.—Drs. Clarence J. Oerter and Ferdinand J. Mueller have been accepted into membership by the St. Clair County Medical Society.

Physicians and Lawyers Meet.—The Belleville and East St. Louis Bar Associations met jointly with the St. Clair County Medical Society in October. Representing the bar association in a panel discussion of medicolegal problems were Attorneys R. G. Ottersen, Norman Gundlach, Robert Brady, P. J. Johnson, and James Vande. Physicians representing the medical society included O. G. Schniedwind, New Athens; Henry H. Hurd, East St. Louis; Jerome J. McCullough, Belleville, and Charles E. Baldree, Belleville.

SANGAMON

New Officers.—Dr. T. D. Masters was recently chosen president of the Sangamon County Medical Society, effective January 2. Other officers include Drs. Henry Berchtold, vice president; William DeHollander, secretary-treasurer; J. Marvin Salzman and Gershom K. Greening, were named to the board of directors for a three year term; Kenneth Schnepp and Darrell Trumpe were designated delegates to the Illinois State Medical Society, and Thomas Harmon and Dr. Salzman, alternate delegates.

Staff Election.—At a recent meeting of the medical staff of St. John's Hospital, Drs. F. Paul La Fata was elected president; Robert A. Nachtwey, vice president, and Earl W. Donelan, secretary. The various sections have named their chairmen as follows: James M. Furrie, surgery; Richard Allyn, medicine; Gerald T. Riordan, obstetrics and gynecology; D. J. Mauro, pediatrics, and Albert T. Kwedar, general practice.

Society News.—At a recent meeting of the Sangamon County Medical Society in the Leland Hotel, Springfield, Dr. Walter J. Reich, professor of gynecology, Cook County Graduate School of Medicine, spoke on "Office Gynecology." Col. Joseph R. Shaeffer, M.C., consultant on medical care in disaster, Walter Reed Army Institute of Research, Washington, D. C., addressed the November 7 meeting of the society on "Medical Management of Disaster."

VERMILION

Society News.—"Spontaneous Subarachnoid Hemorrhage" was discussed by Dr. William F. Meacham, associate professor of neurosurgery, Vanderbilt University School of Medicine, Nashville, before the November 5 meeting of the Vermilion County Medical Society.

Personal.—Dr. Grover Seitzinger has been accepted as a probationary member of the Vermilion County Medical Society; permanent membership will be voted on in one year.

WINNEBAGO

Meeting of Pathologists.—On December 7 the fall meeting of the Illinois Society of Pathologists was held at Rockford Memorial Hospital, Rockford. Participants in a slide seminar were Drs. Marshall O. Alexander, moderator, and Joseph P. Weinmann, C. Bruce Taylor and David O. Holman.

GENERAL

Physicians Named to Tuberculosis Committee.—Governor William G. Stratton has appointed the following physicians to the advisory committee on tuberculosis, which serves as an adjunct to the tuberculosis control service of the state department of public welfare: William E. Adams, professor of surgery, University of Chicago School of Medicine; Eugene Des Autels, chief of tuberculosis service, Veterans Administration, Hines; Leonard Krasner, consultant in thoracic surgery to Chicago State and Veterans Administration (Downey) hospitals; Hiram T. Langston, chief surgeon, Chicago State Tuberculosis Sanitarium; William Lees, chief surgeon, Municipal Tuberculosis Sanitarium; Dan Morse, medical director and superintendent of Peoria Municipal Tuberculosis Sanitarium; Julius B. Novak, medical director of the Tuberculosis Institute of Chicago; Edward A. Piszczek, executive director of Suburban Cook County Tuberculosis Sanitarium District; and George C. Turner, medical director, Cook County Tuberculosis Hospital.

Reappointments to the committee are those of Drs. Kenneth G. Bulley, medical director and superintendent of Kane County Springbrook Sanitarium, Aurora; Clifton Hall, deputy director, division of tuberculosis control, Illinois State Department of Public Health, and David B. Radner, medical director of Winfield Hospital. Ex-officio members of the committee are Drs. Otto L. Bettag, director of the Illinois State Department of Public Welfare, and Ernest Teller, chief of the department's tuberculosis control service.

Tercentenary of William Harvey.—The thirtieth annual scientific sessions of the American Heart Association in Chicago in October commemorated the Tercentenary of William Harvey. A special scientific session was devoted to "Prevention and Management of Cardiovascular Emergencies" at which Dr. Howard B. Sprague, Boston, acted as chairman. Participants were James Metcalfe, Boston, in pregnancy; Benjamin M. Gasul, Chicago, in children; Robert A. Hingson, Jr., Cleveland, during anesthesia; Louis A. Soloff, Philadelphia, after surgery; Maurice Sokolow, San Francisco, during drug therapy, and Stewart G. Wolf, Jr., Oklahoma City, in anxiety states. The session concluded with a panel discussion on "Unsettled Clinical Questions in the Management of Cardiovascular Disease" with Louis N. Katz, Chicago, as moderator. Speakers were Drs. George E. Burch, New Orleans; Albert Dorfman, Chicago; A. Carlton Ernstene, Cleveland; Hans H. Hecht, Salt Lake City; and Robert L. Parker, Rochester, Minn.

Postgraduate Conference—Problems of the gastrointestinal tract were discussed at a Postgraduate Conference held at the Clay County Hospital, Flora, November 7. The meet-

ing was arranged by the ISMS Committee on Postgraduate Education and Scientific Service.

The scientific program was presented by Drs. Walter C. Bornemeier and Sanford A. Franzblau of the Illinois Masonic Hospital, Chicago, and Dr. James D. Majarakis of the Henrotin Hospital, Chicago. Dr. F. W. Siegert, Pana, committee member from the 7th district, presided.

The Clay County Medical Society was host at a luncheon which preceded the scientific program. In the evening, Dr. Raleigh C. Oldfield, Oak Park, president-elect of the ISMS, and Dr. Arthur F. Goodyear, Decatur, councilor for the 7th district, were the dinner speakers. Dr. Thomas L. McCullough, Flora, president of the Clay County Medical Society, presided.

Lectures Arranged Through the Illinois State Medical Society:

Ward Eastman, Peoria, Knox County Health Improvement Association in Knoxville, September 17, on Recent Developments in Cancer.

Joseph T. O'Neill, Ottawa, Marseilles Parent-Teacher Association in Marseilles, November 7, on Your Child's Health.

Margaret M. Kunde, formerly instructor in medicine, Northwestern University Medical School, Hawthorne School Parent Teacher Association, November 12, on Keeping Fit Physically.

Arthur W. Fleming, associate professor of pediatrics, Stritch School of Medicine of Loyola University, Southwest Jewish Congregation, November 19, on Problems of Parenthood.

Edward A. Piszczek, executive director, Suburban Cook County Tuberculosis Sanatorium District, Chicago Jewish Academy Health Class, November 19, on Transmission of Contagious Disease.

Bertram G. Nelson, Oak Park assistant professor of medicine, University of Illinois College of Medicine, Sisterhood of Congregation B'nai Sholom of Garfield Park, November 27, on What's New in Medicine.

H. Paul Carstens, associate in medicine, Northwestern University Medical School, T O P S (take off pounds safely), December 4, on Why Be Fat.

Roger Harvey, professor and head of the department of radiology, University of Illinois College of Medicine, Wright Junior College class in radiological defense, December 16, on Biological Effects of Radiation.

Julius E. Ginsberg, associate professor of dermatology, Northwestern University Medical School, Lindblom Parent-Teacher Association, January 9, on Problems of Skin Care in the Adolescent.

Frederick Stenn, assistant professor of medicine, Northwestern University Medical School, Woman's Auxiliary to the Southern Cook County Branch to the Chicago Medical Society, January 28, on Mental Health.

James E. Segraves, clinical assistant in bone and joint surgery, Stritch School of Medicine of Loyola University, Englewood Branch of the Chicago Medical Society, November 5, on Problems with Three Common Fractures.

R. Charles Oldfield, Jr., clinical assistant in surgery, Northwestern University Medical School, Bureau County Medical Society in Princeton, November 12, on Changing Concepts in Thoracic Surgery.

Lawrence Breslow, clinical assistant professor of pediatrics, University of Illinois College of Medicine, La Salle County Medical Society in La Salle, November 14, on Emotional Problems in Children.

H. Close Hesseltine, professor of obstetrics and gynecology, Stock Yards Branch of the Chicago Medical Society, November 15, on Conduct of Prolonged Labor; Use and Abuse of Pituitary Extract.

Mitchell A. Spellberg, associate professor of clinical medicine, University of Illinois College of Medicine, Lee and Whiteside County Medical Societies in Dixon, November 21, on Modern Management of Liver Diseases.

Ralph E. Dolkart, associate professor of medicine, Northwestern University Medical School, Bureau County Medical Society in Spring Valley, December 10, on Uses and Choice of Corticotropic and Corticosteroid Agents.

Patrick H. McNulty, assistant clinical professor of urology, Stritch School of Medicine of Loyola University, Stephenson County Medical Society in Freeport, December 19, on Hydronephrosis.

Louis C. Johnston, Jr., clinical assistant in medicine, University of Illinois College of Medicine, joint meeting of the Stock Yards and Englewood branches of the Chicago Medical

Society, December 20, on Use of Tranquilizers and Their Value in Hypertension.

John T. Reynolds, associate professor of surgery, University of Illinois College of Medicine, January 7, on Problems of Common Duct Surgery.

Ormand C. Julian, associate professor of surgery, University of Illinois College of Medicine, Stephenson County Medical Society in Freeport, January 16, on Heart Surgery.

DEATHS

Harry W. Ackemann*, Rockford, who graduated at Northwestern University Medical School in 1909, died September 18, aged 72. From 1933-1934, he was president of the staff of the Rockford Memorial Hospital and later served as president of the staff of the Swedish-American Hospital; he was a past president of the Illinois Radiological Society, and a member of the executive committee of the American Cancer Society, Winnebago County Chapter.

George Dionisiou Anagnos, Chicago, who graduated at the Chicago Medical School in 1930, died August 31, ager 59, of acute myocardial infarction and arteriosclerotic heart disease.

Norman L. Bishop, Chicago, who graduated at Loyola University School of Medicine in 1919, died October 8, aged 63. He was a field officer for the Chicago Board of Health for the past 33 years.

Paul Melvin Brenner*, Quincy, who graduated at St. Louis University School of Medicine 1935, died July 16, aged 49, of bronchogenic carcinoma. He was associated with the Blessing Hospital and St. Mary's Hospital, and was a member of the Industrial Medical Association.

Hubert B. Clapp, retired, Chicago, who graduated at Northwestern University Medical School in 1905, died October 26, aged 79. He had served on the staffs of the Chicago Memorial and the Hahnemann Hospitals.

Joseph A. Cunningham, Chicago, who graduated at the Chicago Medical School in 1918, died November 2, aged 76. He was a Board of Health inspector for 49 years.

George S. Duntley*, retired, Macomb, who graduated at Northwestern University Medical School in 1906, died October 13, aged 78.

Joseph S. Eisenstaedt*, Chicago, who graduated at Northwestern University Medical School in 1908, died October 26, aged 72. He was senior attending urologist at Michael Reese Hospital.

Clara Grace Gottschalk*, Chicago, who graduated at the University of Illinois College of Medicine in 1915, died July 21, aged 74, of acute pulmonary edema and arteriosclerotic heart disease.

John D. Guerra*, Chicago, who graduated at Loyola University School of Medicine in 1928, died October 12, aged 57. He was a member of the surgical staff at Augustana Hospital.

William M. Hartman*, Macomb, who graduated at Rush Medical College in 1903, died October 13, aged 77.

Nathan M. Kayne, Chicago, who graduated at Chicago College of Medicine and Surgery in 1913, died October 26, aged 70. He was a member of the staff of the Lutheran Deaconess Hospital.

Julian P. Krakowski*, Camp Point, who graduated at the Chicago Medical School in 1926, died September 7, aged 66.

James A. Laird*, Chicago, who graduated at Rush Medical College in 1930, died October 31, aged 70.

Paul D. Lyons*, retired, Chicago, who graduated at Northwestern University Medical School in 1908, died November 7, aged 73.

Arno B. Luckhardt*, retired, Chicago, who graduated at Rush Medical College in 1912, died in Miami Beach, Florida, November 6, aged 72. He was professor emeritus of physiology at the University of Chicago and discoverer of the anesthetic uses of ethylene gas. He had gone to Florida to attend the American Dental Association convention and was to be presented an honorary membership.

Samuel N. Mallison*, Champaign, who graduated at Creighton University School of Medicine, Omaha, in 1912, died October 5, aged 71. He was health officer of the East Central Region of the State Department of Public Health.

Edward Allen Oliver*, Chicago, who graduated at Rush Medical College in 1909, died November 5, aged 74. He was professor emeritus of dermatology and syphilology at Northwestern University Medical School, dermatologist emeritus at St. Luke's Presbyterian Hospital and consulting dermatologist at Passavent,

*Indicates member of the Illinois State Medical Society.

Chicago Wesley Memorial, Swedish Covenant and St. Francis (Evanston) Hospitals.

John W. Ovitz, Sr.*, retired, Sycamore, who graduated at Northwestern University Medical School in 1909, died September 4, aged 73.

Victor Pacyna, Chicago, who graduated at Harvey Medical College, Chicago, in 1904, died October 18, aged 77. He was founder and first president of the Roosevelt Memorial Hospital.

William Lowrie Porterfield*, retired, McClure, who graduated at Rush Medical College in 1902, died in Baltimore July 20, aged 77. For many years he practiced in Chicago, where he was on the faculty of Loyola University School of Medicine and a member of the staff of St. Bernard's Hospital.

Barash Richman*, Chicago, who graduated at the Chicago Medical School in 1930, died in South Haven, Michigan, August 3, aged 68, of cerebral hemorrhage. He was field health officer for the Chicago Board of Health and served on the staff of the Garfield Park Community Hospital.

Gotthold Steinfuehrer, Chicago, who graduated at the Universität at Leipzig Medizinische Fakultät, Saxony, Germany, in 1921, died June 28, aged 70, of pneumonia and heart disease.

William Thomson*, Cyprus, who graduated at Barnes Medical College, St. Louis, in 1909, died September 24, aged 73.

Clifton Sherwood Turner*, Peoria, who graduated at the University of Cincinnati College of Medicine in 1920, died July 9, aged 62, of arteriosclerotic heart disease. He was past-president of the Peoria County Medical Society, a member and past-president of the staff of the Methodist Hospital.

Walter R. Tweedy*, Royalton, who graduated at St. Louis College of Physicians and Surgeons in 1905, died October 16, aged 79. He was a member of the "Fifty Year Club" of the Illinois State Medical Society.

*Indicates member of the Illinois State Medical Society.

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Lower lumbar disks

The lower lumbar disks are subjected to tremendous loads during lifting. For example, it has been calculated that lifting of 100 pounds in the position of forward flexion produces a load of approximately 1,500 pounds on the lumbosacral disk spaces. It is not surprising that these structures should be vulnerable and slow to heal, once injury has occurred. *Otto E. Aufranc, M.D. et al. Orthopedic Surgery. New England J. Med. May* 23, 1957.

Treatment of amebic abscess

In amebic liver abscess the drug of choice is chloroquine with terramycin to rid the patient of an intestinal infection which must be assumed to be present. The treatment often is successful when the diagnosis is correct, unless there is a secondary extension and infection or a large abscess which requires closed drainage. *Marcel Patterson, M.D. and Virgil Lawlis, M.D. Amebic Liver Abscess. Texas J. Med. March* 1957.



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WOMAN'S AUXILIARY

Our program

"Health Is A Joint Endeavor" is the national theme for 1957-58. Much of our auxiliary work, its projects and objectives are so elosely interwoven, it is difficult at times to tell the boundaries between committees. Because this is true, we urge you to utilize the abilities and knowledge of the chairmen when preparing programs on their subjects. The objectives in our Constitution are a good basis for building your programs for the year for both meetings and auxiliary activities.

Our first objective is to assist the Illinois State Medical Society in its program for the advancement of medicine, public health, and medical education. This means publicizing mental health, public relations, Today's Health Magazine, civil defense, safety, recruitment, and the American Medical Education Foundation. A fine program can be worked out on any of these subjects. Other program materials are: maternal; and child care, school health, nutrition, rehabilitation, problems of the aged and the chronically ill, "A Family Doctor For Every Doctor's Family," and juvenile delinquency. Material and speakers may be obtained by writing the Illinois State Medical Society, 185 North Wabash Avenue, Chicago. Material and films can be obtained by writing the Woman's Auxiliary to the American Medical Association. 535 North Dearborn Street, Chicago 10, Illinois.

Our second objective is to aid in securing better legislation indicated in the pursuance of these ends. No year should pass without a program at one meeting devoted to the study of current medical legislation. A wealth of material is available by writing the office of the Associate Counsel, Mr. Walter L. Oblinger, 420 Reisch Building, Springfield, Illinois for the Springfield Newsletter. It contains information on a national and state level, the stand taken by the Society and why, to whom your letters should be addressed, the name and number of the Bills and the stand taken by representatives and senators in regard to these bills.

Our third objective is to act as liaison between the medical profession and the general public. Here public relations comes forward and can be accomplished through service in the administration of vaccines, staffing blood banks, cancer research programs, Red Cross and many others. Invite individuals and organizations outside the medical profession for an outstanding program.

Our fourth objective is to co-ordinate and advise concerning the activities of constituent auxiliaries. It is up to the county to adapt information to the local situation always with the approval of the local medical society. Foremost in the information department are, our auxiliary publications, the HANDBOOK, the BULLETIN and the ILLINOIS AUXILIARY NEWS. The HANDBOOK tells us how and why, the BULLETIN and our own newspaper the

(*Continued on page* 58)



This unique formulation assures faster and more certain control of urinary tract infections, by providing comprehensive effectiveness against whatever sensitive organisms may be involved. Indicated in the treatment of cystitis, urethritis, pyelitis, pyelonephritis, ureteritis and prostatitis due to bacterial infection. Also before and after genitourinary surgery and instrumentation, and for prophylaxis.

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CAPSULES

NEWS, give much information on current events in auxiliary affairs, reprints of talks and carries the messages of presidents and advisors.

Our fifth objective is to cultivate friendly relations and promote mutual understanding among physicians' families. Establish this friendliness through a social hour, through your special events of a more social nature than educational, and by inviting your neighboring auxiliaries to a meeting or special event. Try drawing out the retiring member, encourage the widow and the new member.

Our sixth objective is to the Benevolence Fund. At least once a year a report should be given. Ways & Means allows many auxiliaries to combine contributions to this worthy project as well as medical education, scholarship loan funds, and many local projects. The national auxiliary asks that high priority be given to these meetings:

1. Use the new auxiliary booklet "Resolutions and Policies" as the basis of a program in every county either as a talk, a skit, an interview or some other interesting form.

2. Have an orientation program on the AMA for the county auxiliary with the medical society. Use one of these:

Films: "The Case of the Doubting Doctor" or "Whitehall 4-1500".

Pamphlet: "AMA in Action" 44 pages illustrated.

3. Suggest that county auxiliaries have a program on discussion methods using one of two pamphlets "My Group and I" and/or "Understanding How Groups Work", or a film on the subject.

This material may be obtained at the national auxiliary office, address given above.

Mrs. George L. Pastnack
Program Chairman

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The auxiliary speaks

The Woman's Auxiliary to the Illinois State Medical Society isn't a social club. We have some very serious work at hand that affects you in an important way. That's right, we said WORK. The kind of work, by the way, if it is not done pretty quick, may prove disastrous to your work.

The County auxiliaries have been organizing clubs in high schools. At first we organized Future Nurse Clubs but now we have gone one big step further and are organizing Health Career Clubs.

Anxiety about a health career is erased from the minds of students who are members of Health Career Clubs because they learn about and understand the responsibilities of health careers. The students explore their feelings by asking questions and we are to give them reasonable explanations. Let us not be evasive but helpful in securing this information and organizing Health Career Clubs in our high schools.

A program of such importance to the medical profession we dare not ignore if our hospitals and other health institutions are to be staffed adequately. Medicine offers attractive and interesting careers for our intelligent youngsters. However, we must tell them about it or they will pass us by in ignorance for careers more widely advertised. Health careers are pleasant, wholesome, and lucrative by comparison with other opportunities and, in addition, carry the respect of the community.

Thank you, doctor, for reading this and please don't forget we need and are depending upon you and your wife in our efforts of giving information to students about these most important health careers.

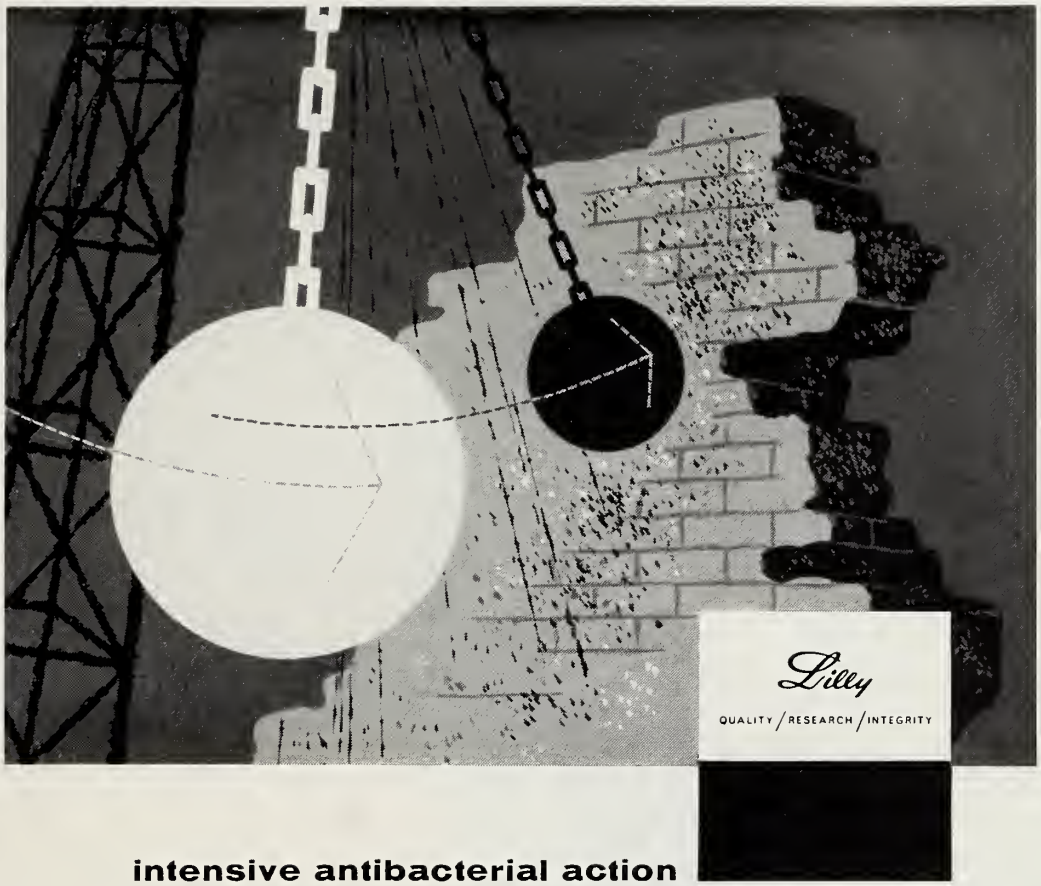
Your chairman will welcome inquiries for more complete information about the work we are doing. Please write.

Mrs. Charles L. Wunsch, recruitment chairman, Woman's Auxiliary to the Illinois State Medical Society, 1219 Downer Place, Aurora, Illinois

‹ ›

SOCIAL SECURITY SAYS: "A woman who becomes entitled to benefits based on her own earnings and also the wife's benefits on the earnings of her husband would receive no more than the larger of the two amounts. A child who becomes entitled to child's benefits based on earnings of both his father and mother would not receive both payments."

In Other Words: Double social security taxes paid by one family do not produce benefits for each member paying the taxes. A part of the taxes go to "charity."



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Effective against a wide range of gram-positive and gram-negative pathogens. The combination of 'Ilotycin' (Erythromycin, Lilly) and the triple sulfonamides is particularly useful in the management of mixed respiratory and genito-urinary tract infections. 'Ilotycin-Sulfa' is notably safe and well tolerated.

Available in tablets containing 75 mg. 'Ilotycin' plus 333 mg. triple sulfas per tablet.

Also supplied as a tasty oral suspension providing in a 5-cc. teaspoonful 200 mg. of 'Ilotycin' as the ethyl carbonate plus 167 mg. each of sulfadiazine, sulfamerazine, and sulfamethazine.

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Carbarsone toxicity

Toxicity to carbarsone does occur. The reactions usually are heralded by gastrointestinal symptoms of epigastric burning, right upper quadrant pain and tenderness, diarrhea, nausea and vomiting, which may progress to exfoliative dermatitis, central nervous system involvement, or hepatic dysfunction. The mechanisms of toxicity appear to be hypersensitivity, direct effect of carbarsone on tissues usually due to overdosage, and/or toxicity of carbarsone preparation containing arsanilic acid. Carbarsone is an effective adjuvant agent in antiamebic therapy and is a relatively safe form of arsenic, but due regard for proper manufacture and storage safeguards must be maintained. Carbarsone should not be prescribed in excess of the dosage plan here outlined—namely 0.25 gm. three times daily for 10 days for average sized males, and twice daily for smaller males and females. The course should not be repeated in less than 10 days after the last dose. British anti-lewisite (BAL), 10 per cent in oil, is effective in therapy of these reactions, but must be employed at the earliest sign of toxicity and in the full dose plan as recommended by the manufacturers. *Ryle A. Radke, M.D. and Waddy G. Baroody, M.D. Carbarsone Toxicity. Ann. Int. Med. Sept.* 1957.

‹ ›

The fragile male

Further research (on the higher death rate in males) presents an interesting and imperative challenge. Fundamental to this research, however, should be an awareness on the part of men that their heavier musculature, which is their biologic badge of masculinity, probably is no longer an advantage in the competition for survival in a western industrialized nation. Indeed, it may even be a liability due to the psychologic role it forces men to play in a society which no longer accommodates that role. Once properly oriented, perhaps men can address themselves to a leisurely search for the causes of their unfavorable mortality ratings. *James O. Bond, M. D. The Fragile Male. Geriatrics. Aug.* 1957.

when anxiety and tension "erupts" in the G. I. tract...

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PATHIBAMATE*

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Combines Meprobamate (*400 mg.*) the most widely prescribed tranquilizer . . . helps control the "emotional overlay" of ileitis — without fear of barbiturate loginess, hangover or habituation . . . *with* PATHILON (*25 mg.*) the anticholinergic noted for its extremely low toxicity and high effectiveness in the treatment of many G.I. disorders.

Dosage: 1 tablet t.i.d. at mealtime. 2 tablets at bedtime. *Supplied:* Bottles of 100, 1,000.

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Each tablet contains:

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

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Each teaspoonful (5 cc.) contains:

ACHROMYCIN® Tetracycline equivalent to tetracycline HCl	125 mg.
Phenacetin	120 mg.
Salicylamide	150 mg.
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Methylparaben	4 mg.
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BOOK REVIEWS



Surgery in World War II. Orthopedic Surgery in the Mediterranean Theater of Operations by Oscar P. Hampton, Jr., M.D., F.A.C.S., Colonel, M.R., U.S.A.R., Assistant Professor Clinical Orthopedic Surgery, Washington University School of Medicine, St. Louis, Mo.

Previous experience had revealed the need for supervision of the management of bone and joint casualties. Orthopedic surgeons without previous military experience — even though they were successful in civilian orthopedic practice — required orientation in the principles and techniques of military surgery. Indoctrination was accomplished through a definite plan for care of casualties. This book records the history of the development of orthopedic service in the armed forces. Many pertinent facts disclosed by experience soon replaced unsound ideas so far as military service was concerned.

Fractures, all compound, are considerated by individual bones. The humerus comes first and the number of such fractures seen in different areas are cited. Problems of management are considered subsequently and then specific cases of compound fracture of the particular bone are presented. This plan follows along for each of the long bones and all sorts of complicating injuries. The immediate treatment and reasons for such procedure are related.

There are 36 tables of statistics concerning the many factors involved in fractures and their complicating injuries. There are nearly 100 illustrations, some diagrammatic, that are helpful in understanding the text.

The descriptions of treatments for compound fractures offers to the physician a tested method for care of a particular case in a technique that has in hundreds of similar cases proved highly successful. Thus the volume is a practical adjunct to the library.

C. P. B.

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The Morphology of Human Blood Cells. By L. W. Diggs, M.A., M.D., Professor of Medicine and Director of Medical Laboratories, University of Tennessee and City of Memphis Hospitals; Consultant in Hematology, Armed Forces Institute of Pathology, Washington, D.C.; Dorothy Stern, Instructor, Memphis Academy of Arts; and Ann Bell, B.A., Instructor in Medicine, University of Tennessee. 181 pages. Illustrated. First Edition. 31 plates. 54 figures. 11 tables. W. B. Saunders Company, Philadelphia and London, 1956, $12.00.

In the last few years several blood atlases have appeared, written primarily for medical students and medical technologists, who for the first time are learning about normal and pathologic blood and bone marrow cells. This volume answers that

(*Continued on page* 68)

FURADANTIN

". . . may be unique as a wide-spectrum antimicrobial agent that is bactericidal, relatively nontoxic, and does not invoke resistant mutants."[3]

■ **RAPID ACTION.** FURADANTIN, a specific for urinary tract infections, provides rapid bactericidal action against a wide range of gram-positive and gram-negative bacteria and organisms resistant to other agents including Proteus and certain strains of Pseudomonas. "Nitrofurantoin (FURADANTIN) has been found to be highly effective in the treatment of chronic urinary tract infection following prostatectomy. Treatment resulted in an abrupt fall in the number of bacteria in the urine, and, in almost one half of the patients, sterile urines were obtained during treatment. The drug was most effective against infections with E. coli and B. proteus."[4]

■ **EXCELLENT TOLERANCE.** There have been no reports of injury to kidneys, liver or blood-forming organs as a result of FURADANTIN therapy. No cases of monilial superinfection, crystalluria or staphylococcic enteritis have ever been reported. In one study, a particularly encouraging finding "was the fact that nitrofurantoin (FURADANTIN) did not cause diarrhea in any of the patients. . . . This might be a consideration in the choice of an antimicrobial drug, particularly if the patient is in the hospital."[3]

■ **NEGLIGIBLE DEVELOPMENT OF BACTERIAL RESISTANCE.** In six years of extensive use in the treatment of genitourinary tract infections, development of bacterial resistance remains negligible with FURADANTIN.

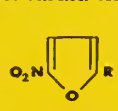
AVERAGE FURADANTIN DOSAGE: In acute, complicated or refractory cases and in chronic infections of adults: 100 mg. q.i.d. In acute, uncomplicated urinary tract infections, for prophylaxis and postoperatively in urologic surgery: 50 mg. q.i.d. (If patient is unresponsive after 2 or 3 days, increase dose to 100 mg. q.i.d.)

SUPPLIED: Tablets, 50 and 100 mg., bottles of 25 and 100. Oral Suspension, 25 mg. per 5 cc. tsp., 60 cc. bottle.

NOW for hospitalized patients, for severe urinary tract infections when peroral administration of Furadantin is not feasible and for serious infections as septicemia (bacteremia) when the bacterium is sensitive.
NEW, LIFESAVING **FURADANTIN** *Intravenous Solution*

FURADANTIN Sensi-Discs for bacterial sensitivity tests are available from Baltimore Biological Laboratories.

REFERENCES: 1. Lich, R., Jr.: J. Arkansas M. Soc. 52:271, 1956. 2. Beeson, P. B.: Yale J. Biol. 28:81, 1955. 3. Waisbren, B. A., and Crowley, W.: A.M.A. Arch. Int. M. 95:653, 1955. 4. Draper, J. W., et al.: J. Urol. 72:1211, 1954.



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Charles S. Gilbert, M.D., *Internal Medicine*
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BOOK REVIEWS (Continued)

need. Emphasis is placed on the characteristics of individual cells and on differential morphology rather than on diseases of the blood and blood forming organs. Smears of human peripheral blood and bone marrows stained with Wright's stain are used. The various cells are painted in water colors and reproduced with an 1800 magnification. The color plates were originally published in "What's New" and later in a monograph by Abbott Laboratories. The color plates are supplemented by black and white and color photographs, ink drawings, tables, and descriptions. The color plates are placed before the text for ready reference and continuity. The terminology used is that recommended by the Committee for the Classification of Nomenclature of Cells and Diseases of the Blood and Blood Forming Organs, sponsored by the American Medical Association (1949-1950).

The idea that little is to be gained by separating normoblasts and megaloblasts will not be shared by most hematologists. Their differences from a diagnostic and therapeutic point of view are too well known to need any comment. There is a short chapter on leukemia and staining of blood and bone marrow cells and suggested collateral reading for students. The plates illustrating mesenchymal cells and granulocytic histiocytes are not true reticuloendothelial cells but damaged cells. These damaged cells are of parenchymal origin and may be either myeloblasts, progranulocytes, myelocytes, or lymphocytes.

This worthwhile book should answer the need for beginners in hematology.

L. R. L.

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THE RECOVERY ROOM, Immediate Postoperative Management. Max S. Sadove, M.D., Professor of Surgery (Anesthesia) and Head, Division of Anesthesiology, University of Illinois, College of Medicine and the Research and Educational Hospital. James H. Cross M.D., Clinical Assistant Professor in Surgery, University of Illinois College of Medicine. W. B. Saunders Company, Philadelphia, London: 597 pages. $12.00.

There has long been a need for a book with this title in our libraries. Much has been written

(*Continued on page* 70)



release from anxiety

ULTRAN

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. . . helps restore normal emotional composure without impairing mental acuity

Dosage:
Usually 1 pulvule t.i.d.

Supplied:
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'Ultran' quickly allays anxiety and tenseness. Broadly evaluated under carefully controlled conditions, 'Ultran' has been shown to be unusually safe. There are no contraindications. It is chemically unique—not related to any other tranquilizer.

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about postoperative eare, but in a haphazard way and not as an entity. The work presented is made up of several treatises, eaeh by a separate author. These eollaborating speeialists are men of high ealiber and all have attained enviable stature in their fields.

Reeovery treatment is presented in detail as to that ordinarily needed and needed beeause of some faetor endangering the smooth reeovery of the patient. Some of the eontributors drift off into verbose dissertations but on the whole postoperative treatment is well explained.

One might find annoyanee in reading so mueh about an intensive therapy unit when he is expeeting postoperative treatment; quite an amount of spaee is taken up with the use of the intensive therapy unit and, in many instances, considering eomplieations or sequelae far removed as to time from the operative procedure. Perhaps the ealiber of the contributing staff made it diffieult for the authors to delete sueh material. The work is well indexed and one might thus avoid the annoyanee of looking over material entirely irrelevant at the moment.

This work is readable and while not presented in essay style yet it is interesting. Many new proeedures, new instruments, new laboratory tests, new medicines, are given. The nursing procedures also are given ample space and in many emergeneies the actions of the nurse spell disaster or recovery for the patient. This after all, and before all else, is the reason for presenting this book.

All eategories of practitioners will benefit by the perusal and application of the prineiples presented in this volume.

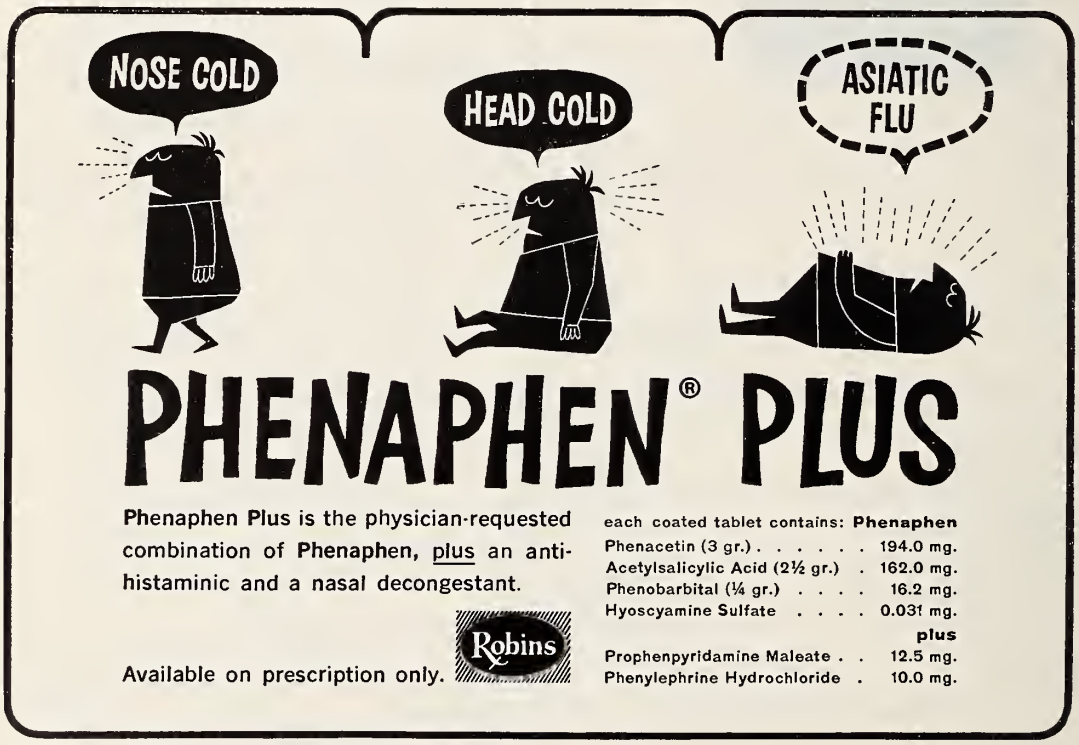
C. P. B.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

Stedman's Medical Dictionary. Nineteenth revised edition, with etymologic and orthographic rules. Edited by Norman Burke Taylor, V.D., M.D., F.R.S.C., F.R.C.S. (Edin.) F.R.C.P. (Can.) M.R.C.S. (Lon.) University of Western Ontario and formerly of the University of Toronto. In collaboration with Lieut. Col. Allen Ellsworth Taylor, D.S.O., M.A., classical editor. The Williams & Wilkins Company, Baltimore. $12.50.

(*Continued on page 72*)

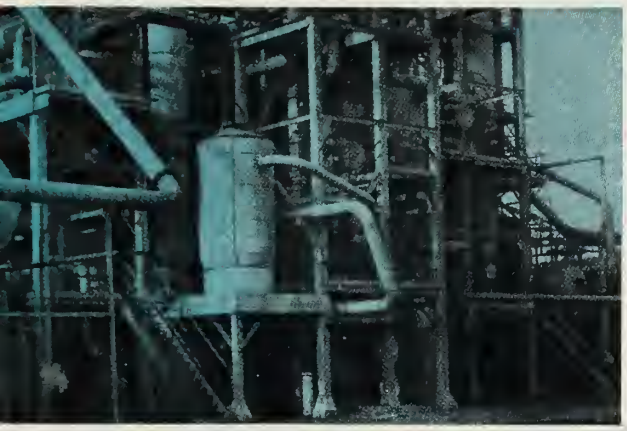


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References
1. King, J. H., Jr.; Passmore, J. W.; Skeehan, R. A., Jr., and Weimer, J. R.: Tr. Am. Acad. Ophth. *59*:759, 1955.
2. Kuhn, H. S.: Tr. Am. Acad. Ophth. *55*:431, 1951.

*T. M.

MM-J-387

Schering

BOOKS RECEIVED (Continued)

THE STORY OF PEPTIC ULCER. Conceived by Richard D. Tonkin, M.D., F.R.C.P., Westminster Hospital, London. Characterized by Raymond Keith Hellier, F.R.S.A. 71 pages. W. B. Saunders Company, London and Philadelphia. $2.25.

MAY'S MANUAL OF THE DISEASES OF THE EYE. For students and general practitioners. Twenty-second edition revised and edited by Charles A. Perera, M.D., Associate Clinical Professor, College of Physicians and Surgeons, Columbia University, New York. 378 illustrations, including 32 plates with 93 colored figures. The Williams & Wilkins Company, Baltimore; $6.00.

REASON AND CHANCE IN SCIENTIFIC DISCOVERY. By R. Taton; translated by A. J. Pomerans. Philosophical Library, New York. $10.00.

FEAR: CONTAGION AND CONQUEST. By James Clark Moloney, M.D., Philosophical Library Inc., New York. $3.75.

INTRODUCTION TO ANESTHESIA. The Principles of Safe Practice. By Robert D. Dripps, M.D., Professor and Chairman, Department of Anesthesiology, School of Medicine, University of Pennsylvania; James E. Eckenhoff, M.D., Professor of Anesthesiology, School of Medicine, University of Pennsylvania; and Leroy D. Vandam, M.D., Clinical Professor of Anesthesia, Harvard Medical School. Line drawings by LeRoy D. Vandam, M.D. 266 pages. W. B. Saunders Company, Philadelphia and London. $4.75.

ALLERGY IN PEDIATRIC PRACTICE. By William B. Sherman, M.D., Associate Clinical Professor of Medicine, Columbia University College of Physicians and Surgeons, and Walter R. Kessler, M.D., Ph.D., Instructor in Pediatrics, Columbia University College of Physicians and Surgeons. Illustrated. The C. V. Mosby Company, St. Louis. $9.25.

THE FUNCTION OF THE URETER AND RENAL PELVIS. An import from Norway. Pressure recordings and radiographic studies of the normal and diseased upper urinary tract of man. By Fredrik Kiil, M.D., Research Associate, Institute for Experimental Medical Research, University of Oslo. 205 pages, illustrated. W. B. Saunders Company, Philadelphia and London, $7.50.

MANAGEMENT OF COMPLICATIONS IN EYE SURGERY: Avoidance of Pitfalls and Treatment of Difficult Situations in Ophthalmologic Operations. Edited by R. M. Fasanella, M.D., Chairman of the Section of Ophthalmology, Yale University School of Medicine. 422 pages illustrated. W. B. Saunders Company, Philadelphia and London; $16.00.

A TEXT BOOK OF X-RAY DIAGNOSIS. By British authors in four volumes. Third edition. Edited by S. Cochrane Shanks, M.D. and Peter Kerley, M.D. Volume 1. 533 illustrations. 521 pages. W. B. Saunders Company, $18.00.

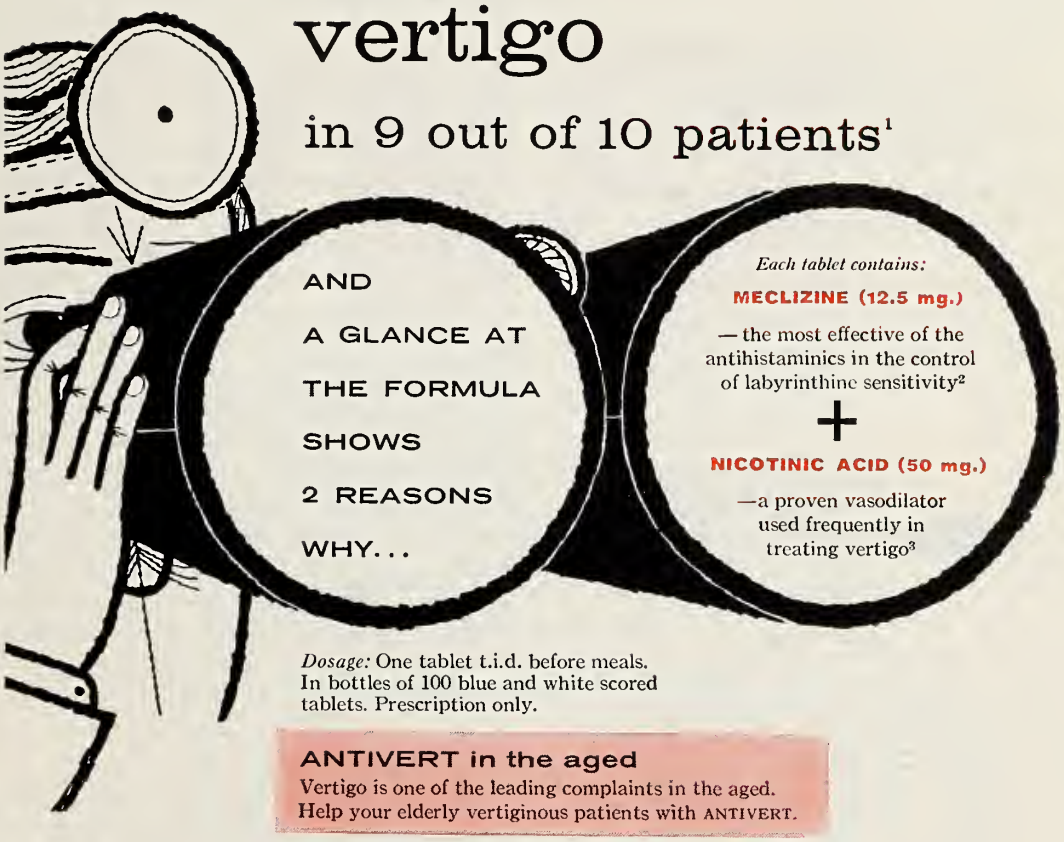


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References: 1. Menger, H.C.: Clin. Med. *4*:313 (March) 1957. 2. Charles, C.M.: Geriatrics *2*:110 (March) 1956. 3. Shuster, B.H.: Med. Clin. of N. Amer. *40*:1787 (Nov.) 1956.

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Public medical assistance

Another change of deep significance to the medical profession is taking place. In the early years of organized relief, the limited money available for public assistance had to be spread over many families, leaving them only enough for food, clothing, and housing. Their medical care was largely a local private charity proposition, with the doctors and the hospitals giving a good deal of service without pay. Over the years, with the expansion of social security and the growth of industrial and private retirement plans, more and more of the necessities of life are being supplied low income groups from sources other than public assistance. As a consequence, more and more public assistance money is being released for medical care, something that few public welfare agencies could afford to supply in earlier days. For a specific example, in two large states 10 years ago, only six per cent of the total welfare dollars was spent on medical care. Today the proportion is 35 per cent, and welfare directors of these states estimate that in another 10 years the proportion will rise to 50 per cent. The explanation is just this: Security and retirement programs, public and private, are underwriting the public's income to such an extent that the share of public assistance money that can be set aside specifically for medical care is growing at a rapid rate. This is evidence that the public assistance programs are increasingly directed toward the benefit of the aged, the sick, and the disabled. American Medical Association. *The Changing Picture: Medical Care Percentage to Increase. Special Report* 85-5. *Sept.* 27, 1957.

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Ball point pens

A recent ruling from the secretary of the Commonwealth states that "no ink contained in ball point pens or fancy colored inks may be used on public records." The use of such inks on birth and death certificates renders them unsuitable for reproduction. In view of the increasing volume of birth and death certificates, the necessity for their proper recording, and the increasing number of requests for such certificates, the department urges all physicians filling out and signing these forms to use standard inks. *Massachusetts Department of Public Health. New England J. Med. Sept.* 26, 1957.

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SULFAMETHOXYPYRIDAZINE (3-SULFANILAMIDO-6-METHOXYPYRIDAZINE) LEDERLE

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- Lowest Oral Dose In Sulfa History – 0.5 Gm. (1 tablet) daily in the usual patient for maintenance of therapeutic blood levels
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- Convenience – the low dose of 0.5 Gm. (1 tablet) per day offers optimum convenience and acceptance to patients

NEW DOSAGE. The recommended adult dose is 1 Gm. (2 tablets or 4 teaspoonfuls of syrup) the first day, followed by 0.5 Gm. (1 tablet or 2 teaspoonfuls of syrup) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours. Dosage in children, according to weight; i.e., a 40 lb. child should receive ¼ of the adult dosage. It is recommended that these dosages not be exceeded.

TABLETS: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

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1. Nichols, R. L. and Finland, M.: *J. Clin. Med.* 49:410, 1957.

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Exertional headache

I do not know of any way to distinguish, on the basis of symptoms alone, between benign exertional headache and headache that is symptomatic of an intracranial expanding lesion. All such headaches must be considered potentially dangerous. However, when the results of a neurological examination are negative, when electroencephalographic and contrast studies reveal no abnormality, or when such headaches have been present for many months or years without progression, it is comforting to realize that such an entity as exertional headache apparently does exist. The characteristics of exertional headache are: Headache is brought on from complete comfort within a few moments, if not immediately, by any exertional maneuver such as coughing, sneezing, straining at stool, bending, or lifting. It may last for a minute or so to an hour but more often is of short duration. It is to be distinguished from the common condition in which a headache already present is made worse by exertional activities. Symonds reported on 17 patients followed for one to 12 years without the appearance of any neurological disease. At the Mayo Clinic, my associates and I have been following a growing group of such patients since 1952. In a recent unpublished survey, we had replies from 28 patients whose headaches had been present for two to 25 years. Their ages ranged from 15 to 70 years but this type of headache appears to be more common after age 50. Many (60 per cent) of our patients have had electroencephalograms, air studies, or angiograms. Of the entire group studied thus far, only two patients later have shown some demonstrable intracranial lesion to explain their symptoms. *E. Douglas Rooke, M.D. Differential Points in the Problem of Headache. Minnesota Med. Sept.* 1957.

« »

I believe that for permanent survival, man must balance science with other qualities of life, qualities of body and spirit as well as those of mind—qualities he cannot develop when he lets mechanics and luxury insulate him too greatly from the earth to which he was born. — Charles A. Lindbergh

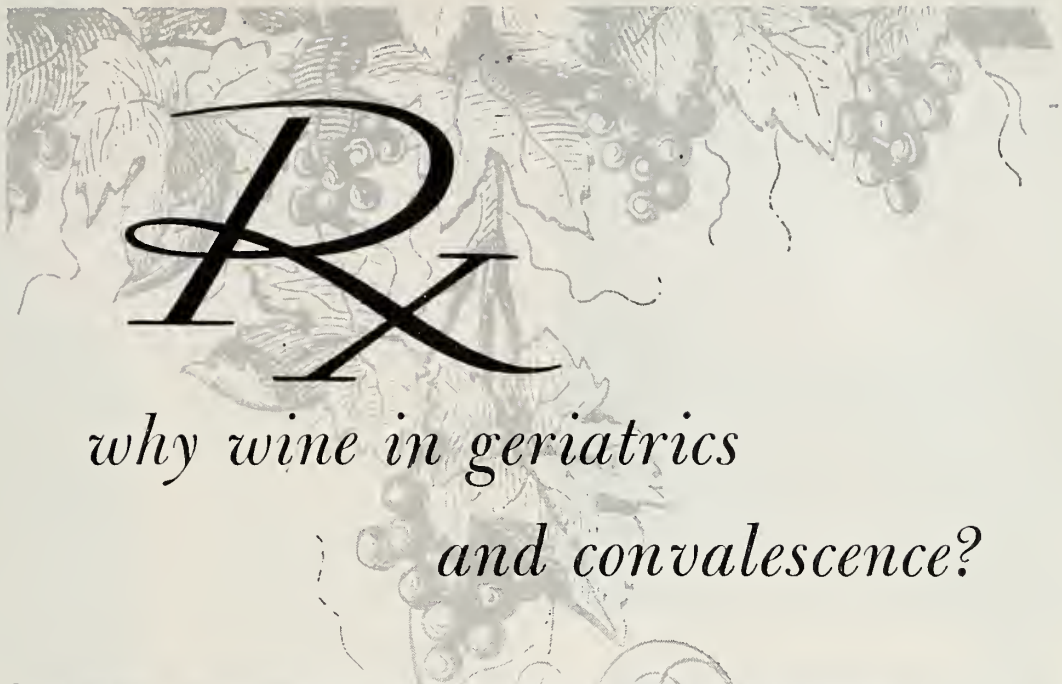
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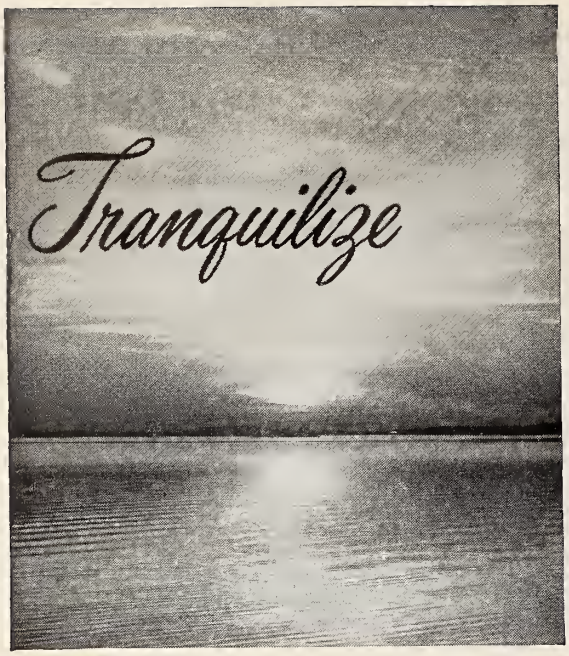
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1. Winsor, A. L., and Strongin, E. I.: J. Exper. Psychol. 16:589 (1933).
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3. Adler, H. F.; Beazell, J. M.; Atkinson, A. J., and Ivy, A. C.: Quart. J. Studies on Alc. 1:638 (1941).
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5. Wright, I. S., Arteriosclerosis, in Steiglitz, E. J.: Geriatric Medicine, Philadelphia, W. B. Saunders Co. (1949).



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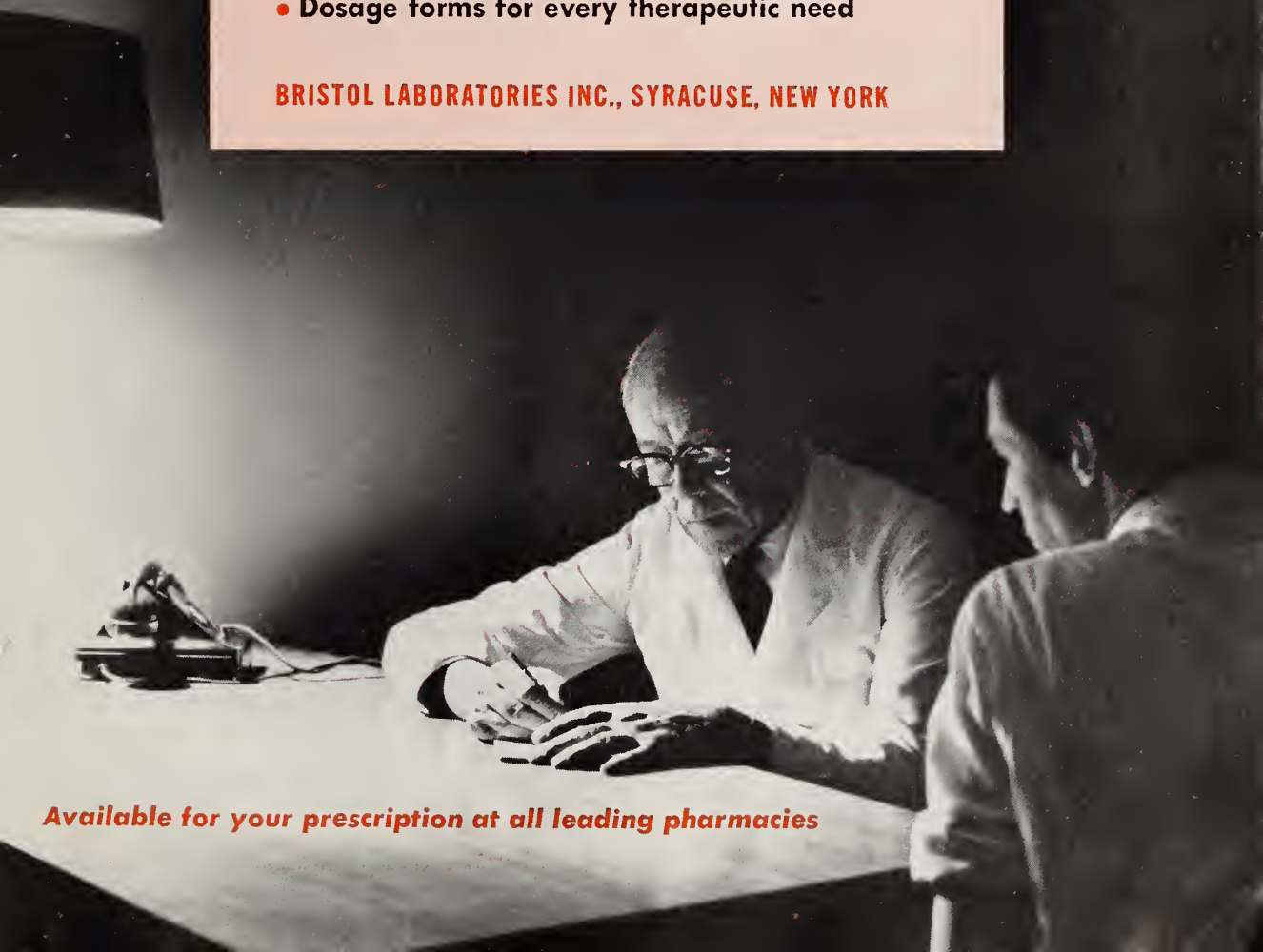
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A family squabble

Stalling and not eating sometimes pay off in a complicated way. I have one patient who is enormously obese and who tells me of the terrible problem she and her husband have about their child's eating. The child refuses to eat whenever Daddy is home, and his father insists that he not leave the table until he finishes whatever is put before him. The father says, "When I was a little boy, there wasn't enough to eat. Now, my child has enough and, by golly, he's going to eat it!" The mother, with her obvious problems of when to eat and when not to eat, finds it very difficult to see the battle going on between her husband and her child. Since it represents her own struggle, she gets involved in it and tries to protect her child. She breaks into tears and her husband flies into a rage. And there's little Johnny, taking all this in, really capitalizing on this opportunity to drive a wedge between father and mother so that he can get priority. Problems of eating, therefore, can involve not only dependency and self-assertion but more complex interfamily relationships. *C. Knight Aldrich, M.D. Prescribing a Diet is Not Enough. J. Am. Dietet A. Aug.* 1957.

SOCIAL SECURITY SAYS: "The following table shows the present tax rates and the scheduled increases: (on $4200 wage base)

Calendar year	Employee	Employer	Self-Employed
1956	2%	2%	3%
1957-59	2-1/4%	2-1/4%	3-3/8%
1960-64	2-3/4%	2-3/4%	4-1/8%
1965-69	3-1/4%	3-1/4%	4-7/8%
1970-74	3-3/4%	3-3/4%	5-5/8%
1975 and after	4-1/4%	4-1/4%	6-3/8%

In Other Words: A recent announcement stated that the Social Security system is in trouble. Benefit funds are melting as applications pour in at a rate in excess of Federal estimates. HEW Secretary M. H. Folsom was quick to say that expenditures may exceed income in 1959, but higher taxes in 1960 will cover the deficit. Check the chart above for proof that our children will be paying the bills for our benefits.

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"I can't do it" never yet accomplished anything; "I will try" has performed wonders. — George P. Burnham

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Treatment of silent gallstones

I should like to raise an issue on the concept of invariable surgical treatment of silent gallstones. Perhaps not all gallstones should be removed on sight, without a closer look at the patient. I believe the incidence of carcinoma of the gall bladder is a rarity compared with the extreme commonness of gallstones, silent and symptomatic. I cannot be moved too much by that argument. My attitude toward silent gallstones is related more to the age of the patient than anything else. The younger the patient who has a silent gallstone, the more years he has to look forward to in which he may expect to undergo the risk of having symptoms and complications. Therefore, the person of 30 or 40 or 50 years who has a gallstone without symptoms, and who is a good surgical risk, should have the gall bladder out to avoid future trouble with it after reaching an age when perhaps other complications would make surgery more hazardous. In a patient 60, 65, and 70 years old, in whom we stumble upon a symptomless gallstone, I cannot get up too much enthusiasm about subjecting the patient to cholecystectomy because of the remote possibility of carcinoma of the gall bladder and certainly not too great a possibility of serious complications when we realize this patient probably has had this stone for many years without trouble and has a good chance of getting along without surgical intervention. *Dolph L. Curb, M.D. Cholecystitis. Texas J. Med. March* 1957.

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Local problems

Like his colleagues west of the Alleghenies, Drake believed that western physicians had more in common with one another than with doctors beyond the mountains. His advice to readers of the first medical journal in the west was typical: "Those who have original matter to communicate should consent to publish it in the interior, where they live and to which it relates, instead of sending it to the periodical presses of the seaboard." *Thomas N. Bonner, Medicine in Chicago* 1850-1950.

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He who would acquire fame must not show himself afraid of censure. The dread of censure is the death of genius. — Simms

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Use of newer therapeutic agents

Employing several newer therapeutic agents and procedures, a correlation of the physiologic changes observed in the laboratory with the clinical improvement observed in patients with chronic dyspneic diseases was made. The changes following the administration of an effective adrenergic and anticholinergic bronchodilator were recorded in patients with bronchospastic disease. A striking reduction in mechanical resistance, increase in pulmonary compliance (lung less stiff), and reduction in the actual work of breathing were demonstrated following six inhalations of an effective adrenergic bronchodilator aerosol preparation (Vaponefrin®). Similar, though less significant, changes were recorded with the use of continuous aerosolization of an effective anticholinergic preparation (Pamine®). The successful evacuation of tracheobronchial secretions was observed following the use of continuous aerosols of two new therapeutic preparations: surface tension lowering aerosols of Tergitol® with potassium iodide and pus liquefying enzyme aerosols of Pancreatic Dornase®. Two new antitussive agents were studied. Neetadon,® an opium alkaloid derivative, was found nontoxic and free of respiratory depressing properties. It was capable of suppressing cough when administered orally in 51 patients. In more than three-fourths of the patient trials, comparable or better effects were observed with Nectadon, when compared with other antitussive agents. Dihydrocodeine,® a successful analgesic agent, was administered intravenously in 30 mg. doses to three patients with chronic bronchitis and chronic pulmonary emphysema. Measurements of minute ventilation, tidal volumes, respiratory rate, and expired carbon dioxide did not reveal any evidence of respiratory depression, following its use. Further studies to evaluate the potential usefulness of this interesting drug as an antitussive agent are in progress. *Maurice S. Segal, M.D. et al. Some Recent Advances in Physiologic Management of Chronic Dyspneic Diseases. Texas J. Med. March* 1957.

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Length of medical training

The question of adequate preparation in liberal education for the needs of medical education introduces the complex problem of the length of time required to produce a physician. This has been a frequent topic of discussion during the last three decades. Telescoping the professional and the undergraduate college courses was a common practice for years. The introduction of the longer hospital period of training plus the requirements of military service after graduation have intensified the challenge to reduce the long span of professional education. In the long run the most satisfactory solution may be not to interfere with the medical course *per se*, which is currently undergoing intensive revisions and improvements, but to strengthen and vitalize the period of secondary and college education. 1957 *Annual Report of Willard C. Rappleye, M.D., Dean, Faculty of Medicine, Columbia University.*

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As Mayo said

Clinically, the ulcerative squamous cell carcinoma connotes greater malignancy than the verrucous or vegetative one. As Mayo said, "A cancer that comes to you is less malignant than one that goes away from you." *Morris Waisman, M.D. Dermatologic Problems of Elderly Persons. Geriatrics. Sept.* 1957.

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